Release 11.3 Notes

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Non-Clinical

Alerts

1. Automatic alert insert from Health Education Class Enrollment
    1. Enroll the patient in a class
    2. Alert inserts automatically
        1. Date and time
        2. Beginning Date = date enrollment is completed
        3. Ending Date = date of the class
    3. For classes with multiple sessions an alert is inserted for each session.
    4. Access Classes from the Scheduler menu
        1. Select the class
        2. Update
        3. Enter the patient number
        4. Message displays to enroll patient for all the classes
        5. Click OK
        6. Patient enrolled in all sessions of the class
        7. Alerts insert.

Authorization

1. Change in header to the Authorization
    1. added: Health Department Name and Address

Billing

1. Able to Query by the Billing Provider
    1. Access the Billing Encounter screen
    2. Query and select the provider from the drop down
    3. Use Next option to see encounters using that provider code

2. Billing Statements address
    1. Affects all of the following
        1. Patient
        2. Contractor
        3. Transaction list
    2. Can use one of the below to print on the statement
        1. Mailing address
        2. Physical address of clinic

See System Administration Notes for address information

3. Billing Output
    1. Access the Billing screen
    2. Choose Output from the menu
    3. Select option
    4. Enter needed dates
    5. Messages in new format
        1. Include zero charges?
        2. Include confidential services?
        3. Responses are Yes or No
    6. Form prints.

4. HCFA Forms

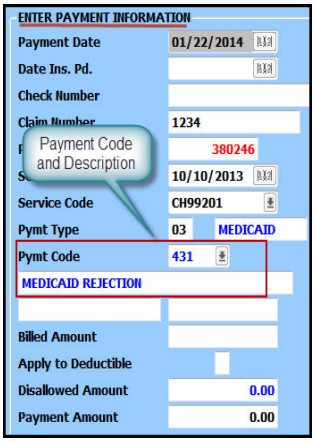
    1. Applies to both HCFA and the MDCR HCFA
    2. Address in Block 33 controlled by check box in maintenance tables
    3. Allows 3 options for the billing address/payer
    4. LHD decides on the options to use.
        1. Billing address
        2. Center Address
        3. Pay to Address
    5. Selection applies to Batch as well as individual HCFA

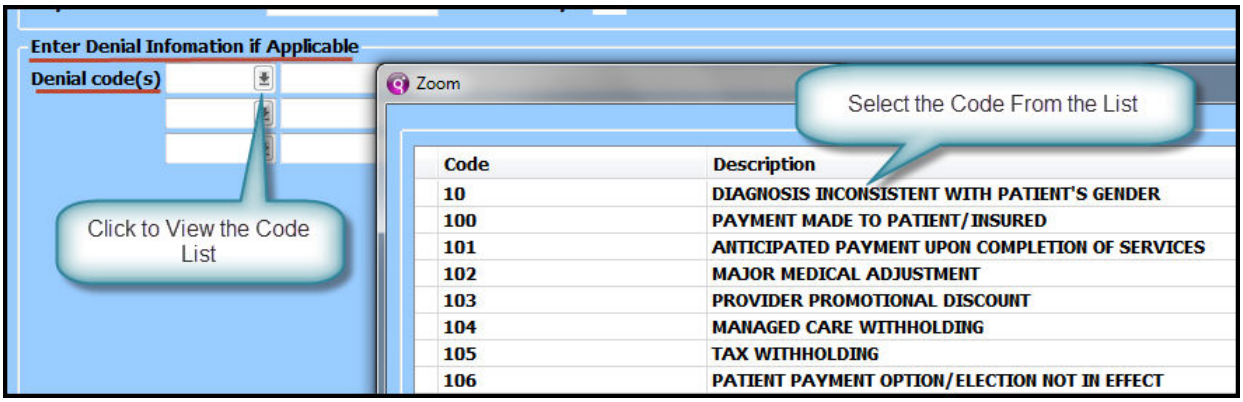
See System Administrators Notes for Set-up

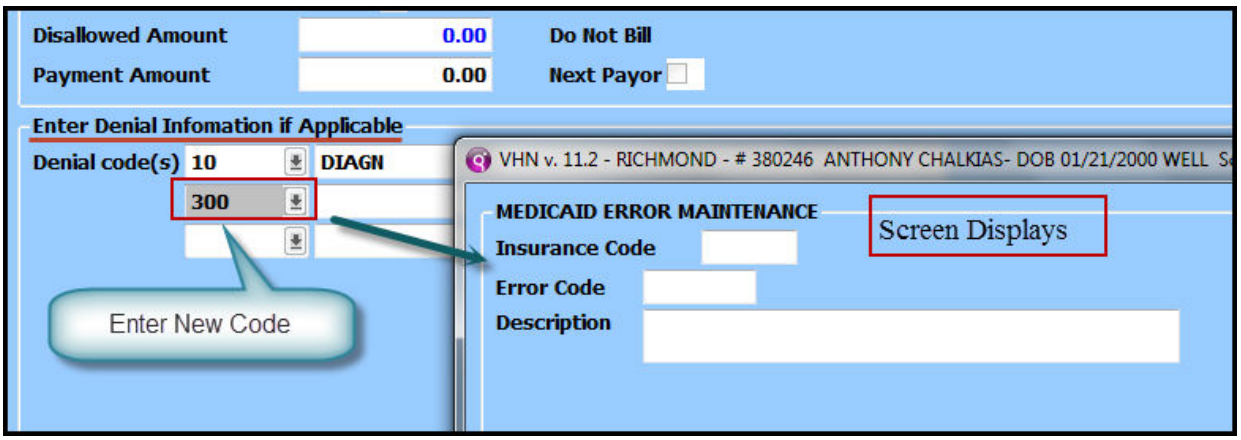
5. Denial Codes used for non-electronic remittances
        1. When posting payments manually can add up to 3 denial codes
        2. Allows users to enter denial codes at time of posting
    2. From the Billing menu choose view post
        1. Click Post Payment
        2. Select the line to be posted
            1. Use the payment code for the service that was not paid. This will vary
            2. Enter the Payment Amount of 0.00
            3. Inserts into the correct remittance file based on the Payment Type
                1. 03 into Medicaid Remittance file
                2. 04 into Insurance Remittance file
                3. 05 into Medicare Remittance file
        3. New fields added to the screen to enter the Denial Codes for this service

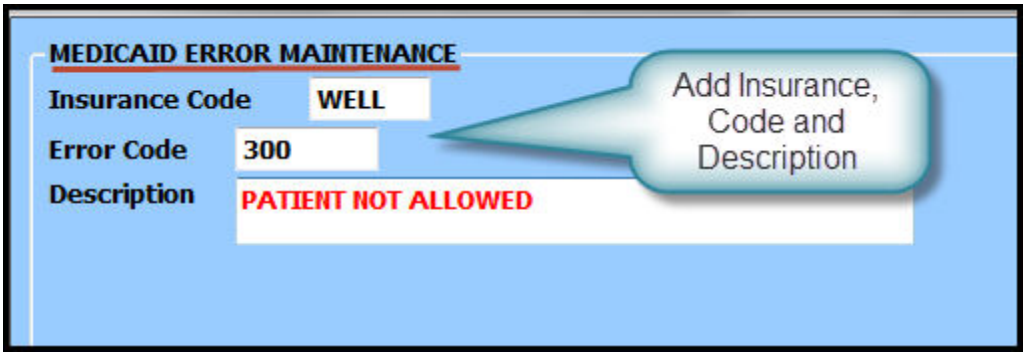
1. Enter up to 3 codes
2. Codes pull from the error file in the Maintenance Tables
3. User, with appropriate permission, can add codes at the time of posting.
    1. Enter the code
    2. Screen displays to allow user to enter code and description
    3. Add:
        1. Insurance Code
        2. Code
        3. Description of error
        4. OK: to save new code in the appropriate Error table

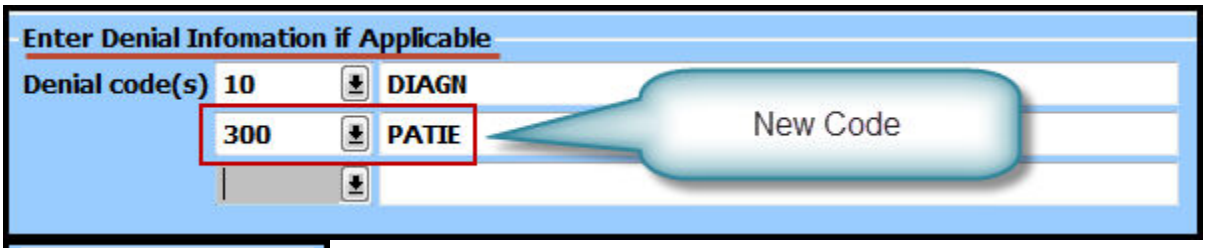
4. Updates the Billing History screen
    1. Record in the Billing History has to match the record in the Billing screen
    2. System inserts the Amount Paid and the Remit Status
    3. Click on the BillingHist button to see the billing history.

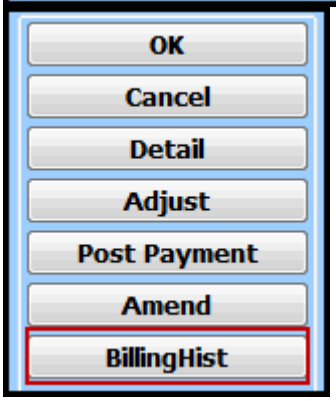





Disallowed Amount
0.00
Do Not Bill
Payment Amount
0.00
Next Payor
Enter Denial Infomation if Applicable
Denial code(s) 10
DIAGN
300
Enter New Code
VHN v. 11.2 - RICHMOND - # 380246 ANTHONY CHALKIAS- DOB 01/21/2000 WELL
MEDICAID ERROR MAINTENANCE
Insurance Code
Error Code
Description
Screen Displays


MEDICAID ERROR MAINTENANCE
Insurance Code
WELL
Error Code
300
Description
PATIENT NOT ALLOWED
Add Insurance, Code and Description


Enter Denial Infomation if Applicable
Denial code(s) 10
DIAGN
300
PATIE
New Code


OK
Cancel
Detail
Adjust
Post Payment
Amend
BillingHist

6. Write-offs
    1. Lists write-offs per patient or guarantor
    2. Service date
    3. Service code
    4. CPT Code
    5. Full charge
    6. Any amount due remaining
    7. Payment type
    8. Amount written-off
    9. Totals the amount written-off for this patient
        1. Access the billing screen
        2. Select the mode: patient or guarantor
        3. Select Output/Write-offs
        4. List prints

7. Confidential billing
    1. New field added to billing records
        1. Allows LHD to control the confidentiality of individual billing records
            1. Applies to transactions for all payment types 03(Medicaid), 04(Commercial Insurance) and 05(Medicare)
            2. Confidentiality applies to the individual insurance
                1. Each insurance in a payment type can be different
                2. Can be changed as needed in the billing screen.
                3. Works with the Central Registry, "OK to Contact" option
            3. Completed when the bill is generate
            4. Release install will set the flag to "N" (No) for both options
        2. Options:
            1. Omit Confidential Patients from Billing Generation = "Y"
                1. Patient is OK to Contact = No
                    1. Flag set for Insurance type ABC to Omit Confidential Patient from Billing Generation
                    2. Billing records insert with Confidential = "Y" (yes)
                    3. Billing records display in **Red** on the Billing Screen
                    4. Record does not insert into the billing file generation for insurance ABC
                2. Patient's with OK to Contact = Yes will bill as before.
            2. Omit Confidential Encounters from Billing Generation = "Y"
                1. Patient is OK to Contact = "Yes"
                    1. Flag set for Insurance type ABC to Omit Confidential Encounters from Billing Generation
                    2. Encounter is Confidential

1. System generated for program
2. Manually set when Service Slip is created

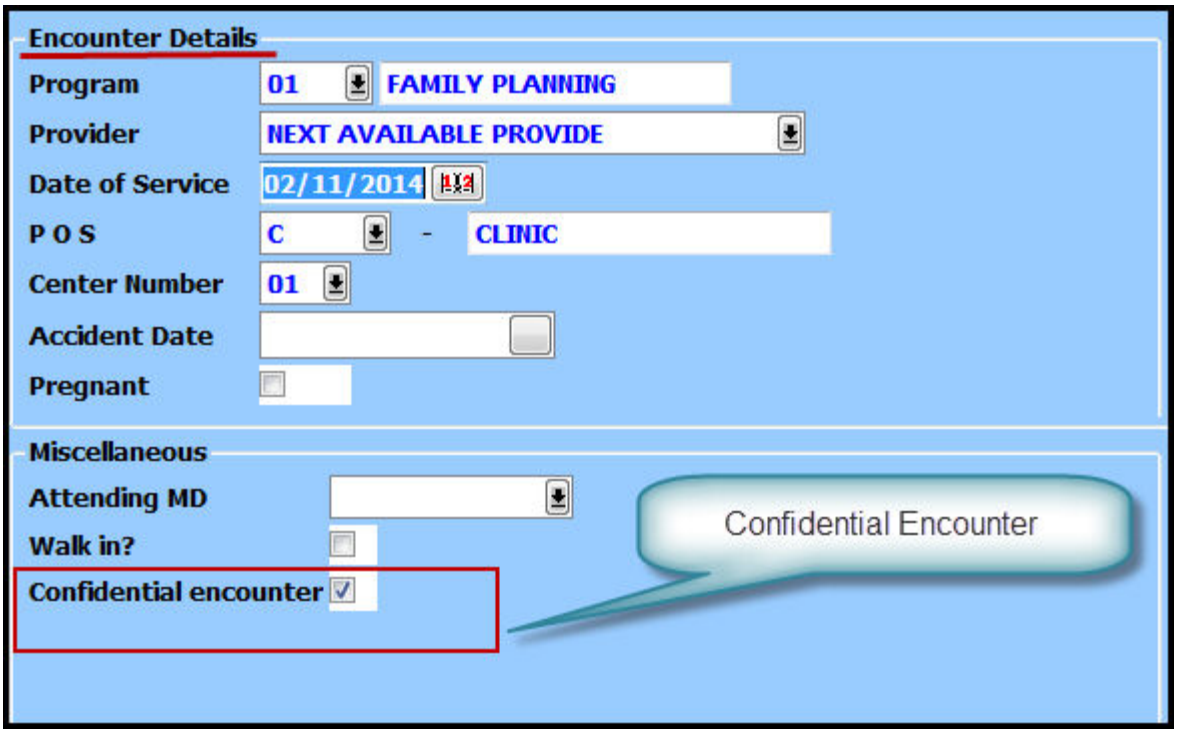
3. Billing records will generate with Confidential = "Y" (yes)
4. Billing records display in **Red** on the Billing Screen
5. Record does not insert into the billing file generation for insurance ABC

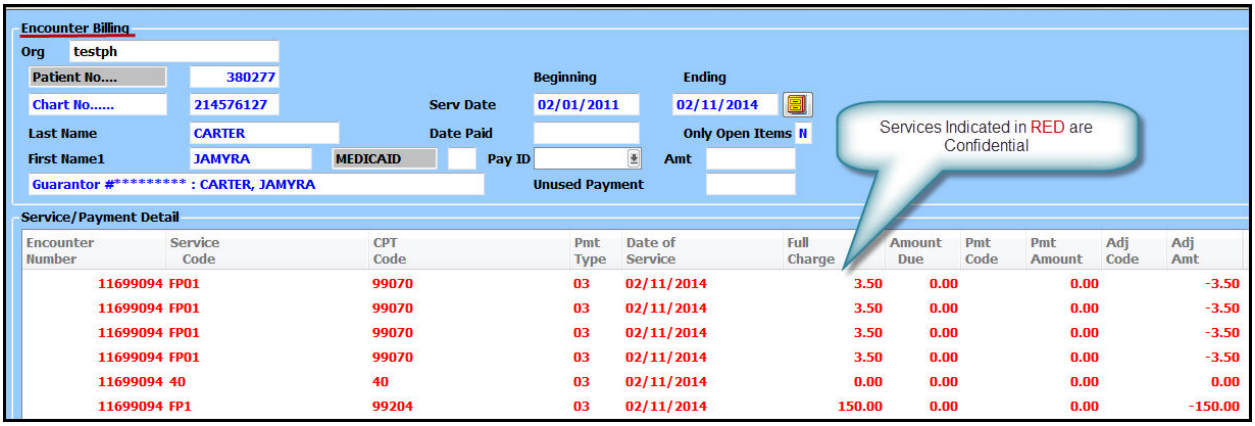
3. If both options are set to "Y"
    1. Any service for a confidential patient (OK to Contact = "No") is omitted from the billing process for that insurance
    2. Where the patient is not confidential (OK to Contact = "Yes")
        1. Confidential Encounters will be omitted from the billing process for that insurance
        2. Encounters that are not Confidential will be as usual
4. If both options are set to "N"
    1. Patient is OK to Contact = "No"
    2. Encounter is Confidential
    3. Billing will generate for that insurance

3. Confidential Records
    1. Records not included in the billing creation will be included on the Error Report
    2. Records will be indicated with "Confidential" list as the exclusion reason
    3. To make needed corrections to submit "Confidential" services
        1. Access the Billing Screen (Billing/Bills)
        2. Click Visit Review
            1. Update
            2. Highlight the line to correct
            3. Uncheck the Confidential box to bill
        3. Click View Post
            1. Choose Amend
            2. Highlight the line to correct
            3. Uncheck the Confidential box to bill
4. Self-Pay patient billing
    1. Previously only Confidential Encounters and/or Services were omitted from self-pay billing
    2. Now will omit billing where patient is marked Confidential (OK to Contact = "N")
    3. Confidential services will be listed on the Error Report
5. **Georgia Medicaid Only**:

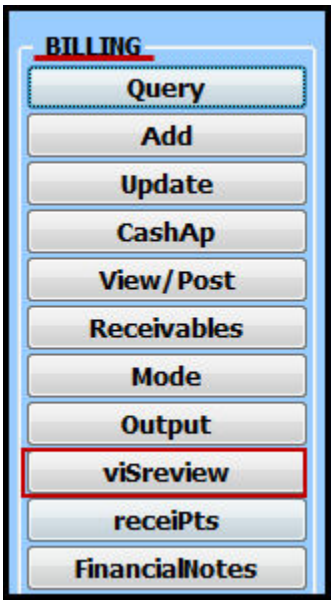
1. Confidential patients, encounters and services **WILL** be generated into the 02 Billing Screen
2. Confidential services will be omitted during the billing file generation
    1. Confidential services are included in the Error Report
    2. See above to make corrections if needed
3. Confidential indicator will display on 02 Billing Screen.
   Display Only on Confidential Services.

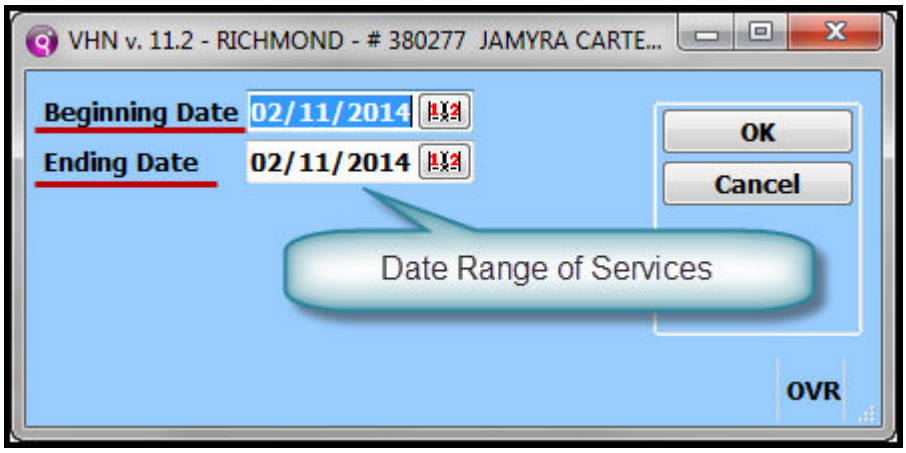
See System Administration Notes to set flag.

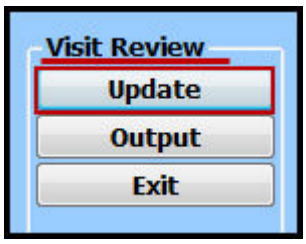

Encounter Details
Program
01
FAMILY PLANNING
Provider
NEXT AVAILABLE PROVIDE
Date of Service
02/11/2014
P O S
C
CLINIC
Center Number
01
Accident Date
Pregnant
Miscellaneous
Attending MD
Walk in?
Confidential encounter
Confidential Encounter

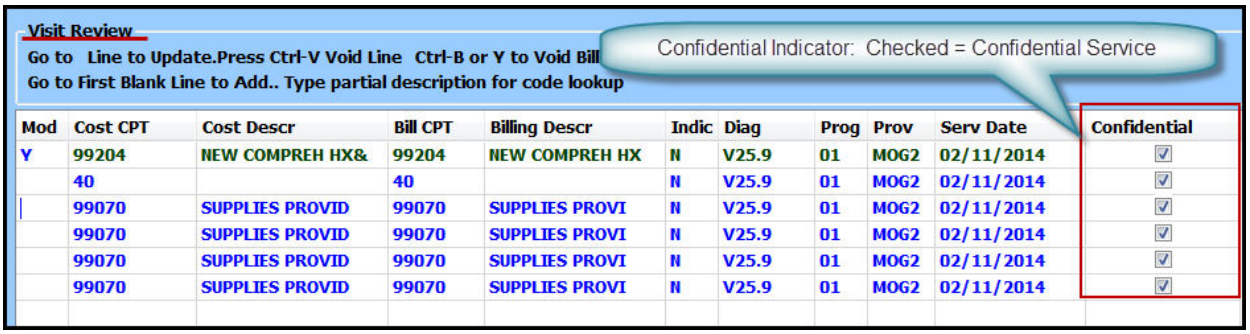

Encounter Billing
Org testph
Patient No.... 380277
Chart No..... 214576127
Last Name CARTER
First Name1 JAMYRA
MEDICAID
Guarantor #********* : CARTER, JAMYRA
Beginning
Ending
Serv Date 02/01/2011 02/11/2014
Date Paid
Only Open Items N
Pay ID
Amt
Unused Payment
Services Indicated in RED are Confidential
Service/Payment Detail
Encounter Number | Service Code | CPT Code | Pmt Type | Date of Service | Full Charge | Amount Due | Pmt Code | Pmt Amount | Adj Code | Adj Amt
11699094 FP01 99070 03 02/11/2014 3.50 0.00 0.00 -3.50
11699094 FP01 99070 03 02/11/2014 3.50 0.00 0.00 -3.50
11699094 FP01 99070 03 02/11/2014 3.50 0.00 0.00 -3.50
11699094 FP01 99070 03 02/11/2014 3.50 0.00 0.00 -3.50
11699094 40 40 03 02/11/2014 0.00 0.00 0.00 0.00
11699094 FP1 99204 03 02/11/2014 150.00 0.00 0.00 -150.00

Visit Review



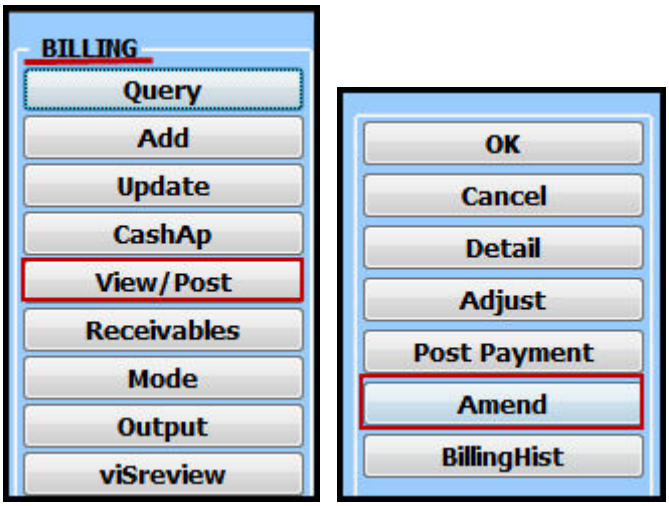


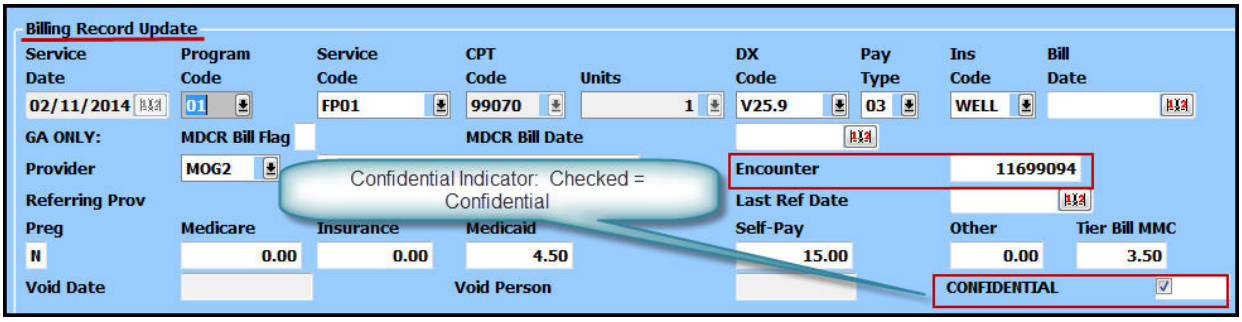



Visit Review
Go to Line to Update.Press Ctrl-V Void Line Ctrl-B or Y to Void Bill
Go to First Blank Line to Add.. Type partial description for code lookup
Confidential Indicator: Checked = Confidential Service

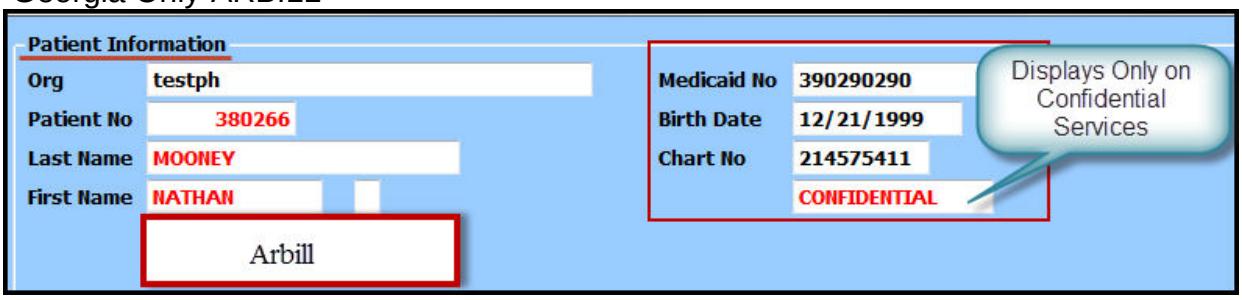
Mod	Cost CPT	Cost Descr	Bill CPT	Billing Descr	Indic	Diag	Prog	Prov	Serv Date	Confidential
Y	99204	NEW COMPREH HX&	99204	NEW COMPREH HX	N	V25.9	01	MOG2	02/11/2014	☑
	40		40		N	V25.9	01	MOG2	02/11/2014	☑
	99070	SUPPLIES PROVID	99070	SUPPLIES PROVI	N	V25.9	01	MOG2	02/11/2014	☑
	99070	SUPPLIES PROVID	99070	SUPPLIES PROVI	N	V25.9	01	MOG2	02/11/2014	☑
	99070	SUPPLIES PROVID	99070	SUPPLIES PROVI	N	V25.9	01	MOG2	02/11/2014	☑
	99070	SUPPLIES PROVID	99070	SUPPLIES PROVI	N	V25.9	01	MOG2	02/11/2014	☑

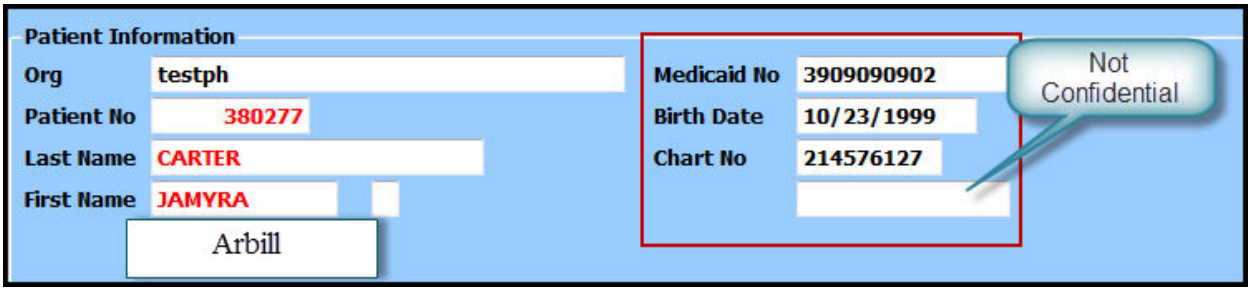
View/Post





Georgia Only-ARBILL





Notifications

1. Change in the Copy To process
    1. No longer defaults to person Sending the notification
    2. Access Notifications
        1. System continues to insert user logged in as the sender
        2. Copy to is blank
        3. User can add self to Copy To if desires a copy.

Central Registry Screens

1. New field added to Emergency Contact
    1. Relationship drop down

See System Administration notes for Valid Codes

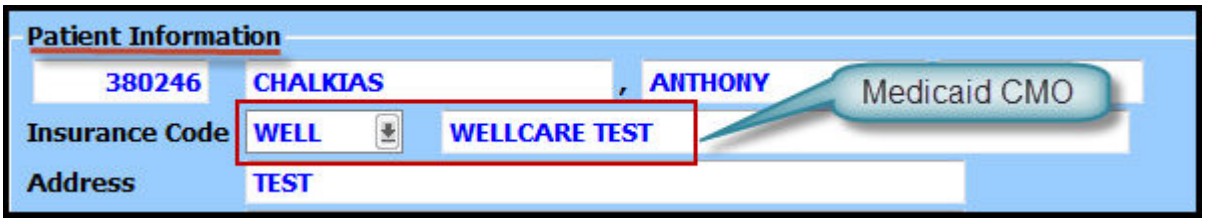
2. Guarantor
    1. The Guarantor screen now has an expiration date
    2. Expiration Date entered the expiration date
        1. In the Maintenance Screen under Guarantor
            1. Contracted Agencies
            2. Employers
            3. Parent/guardians that change responsibility
        2. Page 3 of the Central Registry Screens
            1. In Update or Add access the Guarantor Screen
            2. Enter the expiration date
            3. Complete the Eligibility Screen
            4. OK
            5. Responsible Party is blank
            6. Update to enter a new Responsible Party if needed
        3. Expired Guarantors:
            1. Not available for creating encounters (service slip)
            2. Will generate billing records for service
            3. Removed from the Guarantor drop down list

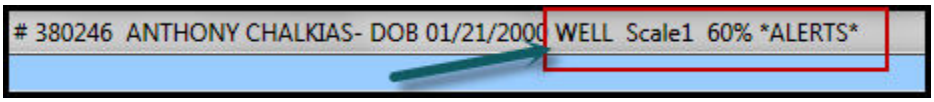
3. Relative Information
    1. Added second relative information to page 2 of Patient Central Registry
    2. Allows user to enter both parents or other relatives if needed

1. Access Patient screen
2. Update an existing patient or enter when Add a new patient
3. Move to Screen 2
4. Enter the Relative Information

Display Banner

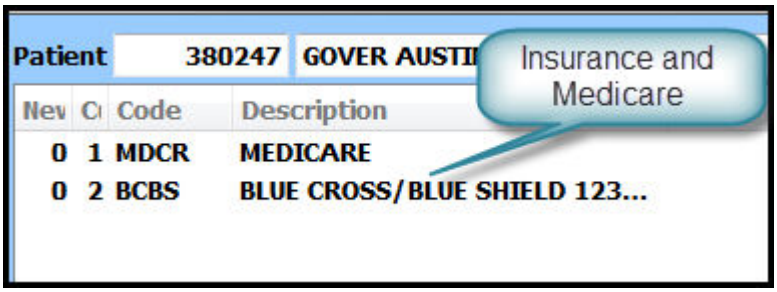
1. Changes to the Display Banner for Insurance Display
    1. LHD Specific No changes for other LHD
    2. Georgia
        1. Medicaid type added to the display
            1. Type code must be in 3Pinsurance under type
            2. Choose from the drop down.
        2. Medicaid CMOs now on the display banner

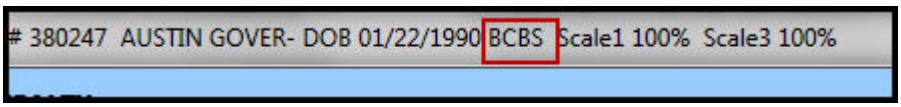




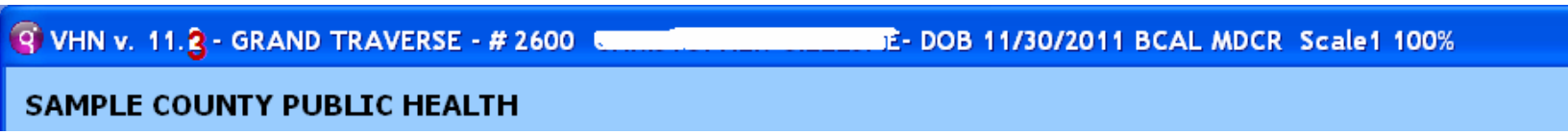
Buncombe County North Carolina

1. Sequence as follows
    1. Medicaid and type
    2. MDHC displays alone
    3. Medicaid and Insurance
    4. Insurance alone if no Medicaid
    5. Insurance and Medicare the Insurance displays


Patient 380247 GOVER AUSTI
Insurance and Medicare
Nev C Code Description
0 1 MDCR MEDICARE
0 2 BCBS BLUE CROSS/BLUE SHIELD 123...



Grand Traverse Michigan
Will display 1st priority for each Payment Type



File Cabinet

1. Add categories to the file cabinet for scanned documents
    1. Category assigned to form/file when imported
        1. Access:
            1. File cabinet on the clinical toolbars
            2. Imported Documents menu option on Patient/Central Registry
        2. Click import
        3. Select the document to import
        4. At the Import Document screen
            1. Enter the title of the document
            2. Select the category from the drop down
        5. Document displays with the category type
        6. Category type sort
            1. Put the mouse cursor on the column name
            2. Click the left mouse button and the column will group items by the category

3Pinsurance Screen

1. Policy/Contract #
    1. Only accepts alpha or numeric characters
        1. No long allows special characters (!@#-)
        2. User receives warning message if special characters used
        3. Click OK on the Error Message
        4. Forces user back to Policy/Contract # field
        5. Must correct to alpha/numeric to continue through screen

Progress Notes

New printout display

1. Prints Created by
2. Prints date created
3. Prints time created
4. If signature required still prints "Electronically signed by"
5. On every page prints
6. Patient name
7. Patient number
8. Date printed
9. Page numbers

Service Slip

1. Reason for Visit
    1. Drop down added in 11.2
    2. Standard items for the health department will display
    3. Now can limit drop down by program
    4. Items not designated with a program will display for all programs

See System Administrator notes for set-up

Central Office Payment Posting Across Organizations

Some agencies have central billing offices that post payment received in multiple organizations that are in different Public Health database instances (organizations) on the central servers.

Georgia

The option to change to a different organization to facilitate payment posting will be available in patient billing screen AND 02/FP Medicaid ARBILL table.

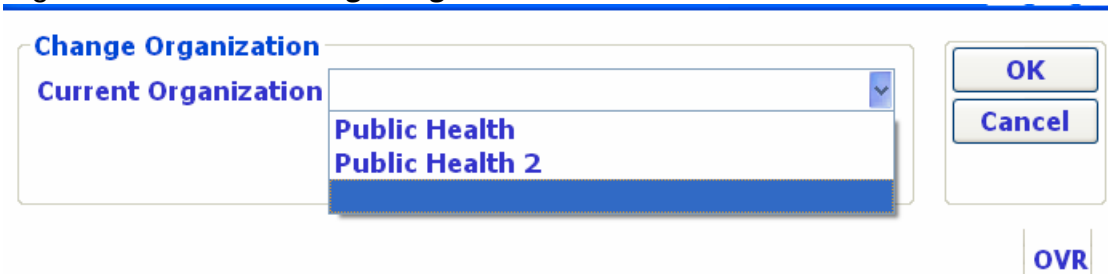
Other States

The option to change to different organization to facilitate payment posting will be available in patient billing screen. Other states do not use the ARBILL table for Medicaid billing.

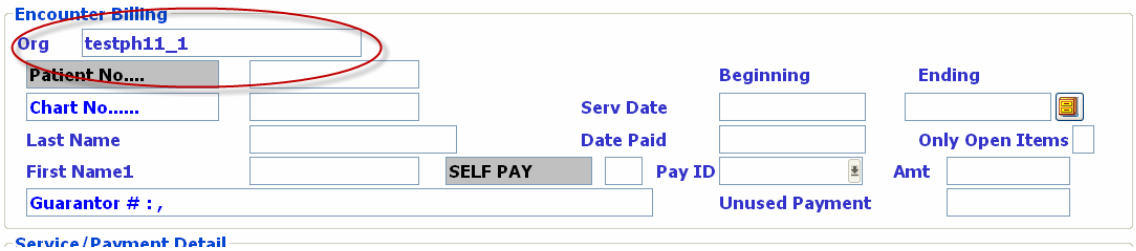
Patient Billing Screen

To do this, the user MUST know the patient # in the other organization. In billing it can only be queried by patient # after changing organization.

In the patient billing screen, when the user is ready to change to a different organization, click ***Change Organization*** button.



Select the organization to change to for other payment postings. **Be very careful when doing this because you do not want to post to the wrong patient in the wrong organization.**



Once the organization has been selected, the screen will now display a different organization at top of screen. **Confirm** you are in the correct organization.

Query by ***patient number***. This is the only way to find a patient after changing organization. If will default the original patient number from the previous organization so ***change*** it to the ***patient number*** you want in this organization.

After new patient from the different organization in on the screen, the user may post the payment as usual. When finished and exiting out of billing screen, the user will be returned to original organization

Georgia Only Medicaid ARBILL Screen
From Medicaid bills screen, after posting in the current organization, click Change Organization button.

After selecting new organization, ***Query*** for patient to post payment. After record appears to post, proceed with usual way of payment posting. When Exit from screen, user will be returned to original organization.

Clinical

Case Management

1. Case Management Module now available
    1. Can be customized for any case management program
    2. Standard care plans can be added for each program
    3. Set-up and training is done by M&M staff in conjunction with the local program

- Requesting a demonstration of the new module.
- Discovery and analysis by M&M staff
- Set-up assistance
- Training.

Clinical Encounter

1. Added the Center number to the Encounter
    1. Allows user to verify center where patient is receiving services
    2. Allows clinician to note center where services were last entered
    3. Reflects the center number for the encounter for that patient that day of service.
    4. Must be changed on patient central registry under Billing then Encounter screen. Cannot be changed from the Clinical Encounter

Reminder: Patient's center number and user's center number must match!

Smoking status insert

1. Smoking status now part of the encounter note
2. Section determined by LHD
3. Displays on encounter with Code number and description
4. Displays if entered through Encounter Info or Smoking Status as individual workflow item
5. Any change to the smoking status before the encounter is signed will change the entry on the note.

See System Administration notes for set up of workflow and encounter note

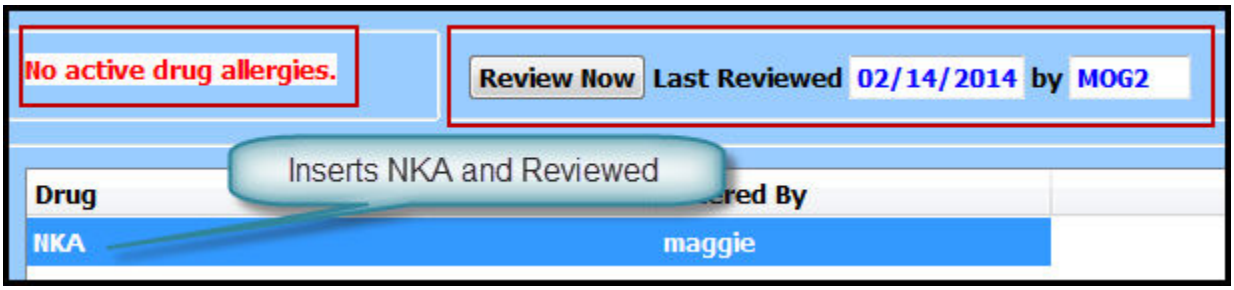
3. Education Documents added to Note configuration
    1. Select Document from the workflow
    2. Education Document inserts automatically into the encounter note

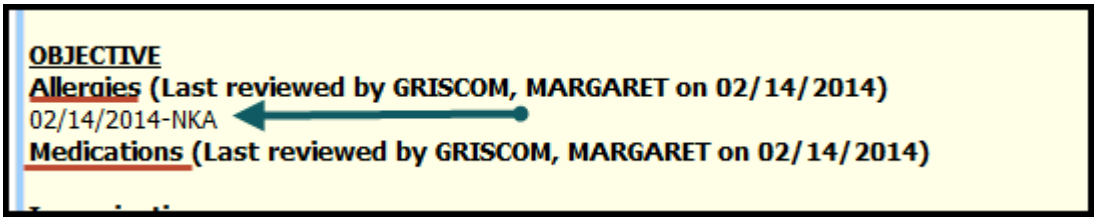
See System Administration notes for placement in the encounter note

4. Program Details
    1. Changes to Program Details require an addendum to be written
        1. Encounter is signed
        2. Select Program Details from workflow to make a change
        3. Message displays to create an addendum
            1. Yes = the Program Details Screen displays
            2. No = the user is returned to the encounter screen.
        4. Change the Program Details
        5. Create the Addendum

2. Program Details no longer requires Time and Activity code for Workflow to check

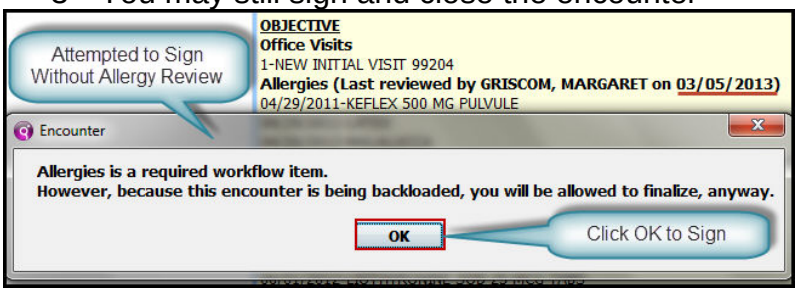
5. Review Medications and Allergies
    1. Now will insert Reviewed by even if no items in the lists
        1. Allergies should always have NKA to insert in Encounter Note
        2. Medications inserts that Medications History was reviewed




OBJECTIVE
Allergies (Last reviewed by GRISCOM, MARGARET on 02/14/2014)
02/14/2014-NKA
Medications (Last reviewed by GRISCOM, MARGARET on 02/14/2014)

Entering an encounter for a previous date

1 When an encounter has to be put in late on another day, the items in the workflow that are required may be skipped. It will not check off allergies and medication reviews if encounter date is prior to the date entered.
2 The items will not check off in the workflow and the user will still receive a warning stating that required items were not completed but will allow them to proceed since it is a back loaded entry
3 You may still sign and close the encounter


Attempted to Sign Without Allergy Review
OBJECTIVE
Office Visits
1-NEW INITIAL VISIT 99204
Allergies (Last reviewed by GRISCOM, MARGARET on 03/05/2013)
04/29/2011-KEFLEX 500 MG PULVULE
Encounter
Allergies is a required workflow item.
However, because this encounter is being backloaded, you will be allowed to finalize, anyway.
OK
Click OK to Sign

Consult Form

1. Allows preview before printing now.
    1. Access from the Patient Summary Screen
    2. Choose Print_Consult.
    3. Displays PDF preview so able to check for errors.

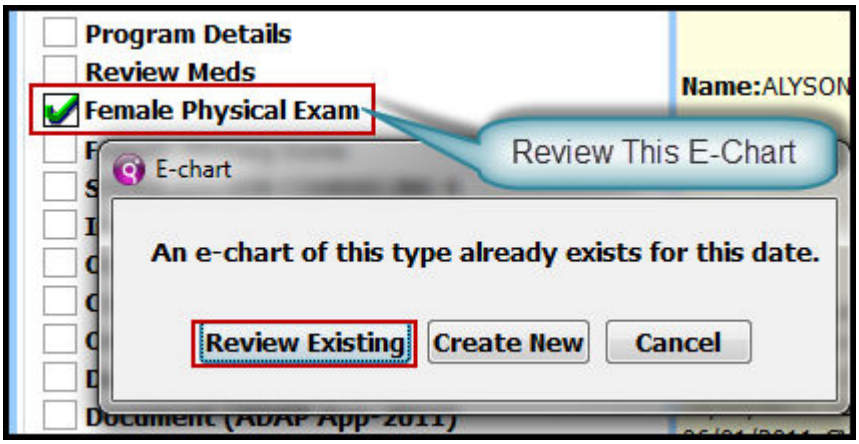
E-Charting

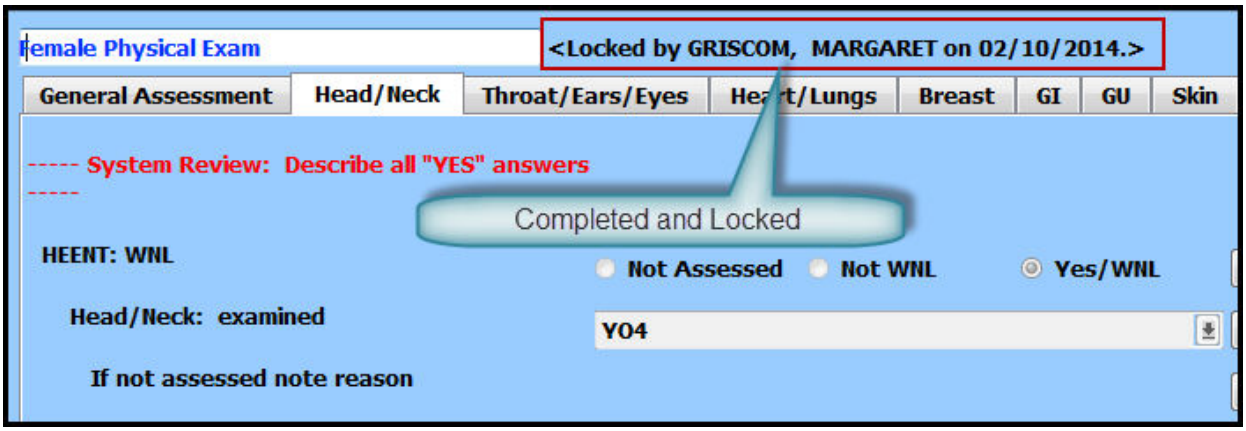
1. Ability to Void an e-chart
    1. Signed e-charts
        1. User that **created** and/or **signed** the e-chart can void with or without the permission flag set
            1. Select the e-chart to be voided
            2. Note: User's signature
            3. Click Void
            4. Verify that the record is to be voided
            5. Enter login and password. In this case same user that signed
            6. Displays message that record is voided
            7. Record removed from the e-chart summary list
        2. User that did **Not** create or sign an e-chart must have permission flag set in the Provider table to "Y" to void any e-chart
            1. Select the e-chart to be voided
            2. Note: User's signature
            3. Click Void
            4. Verify that the record is to be voided
            5. Enter login and password.

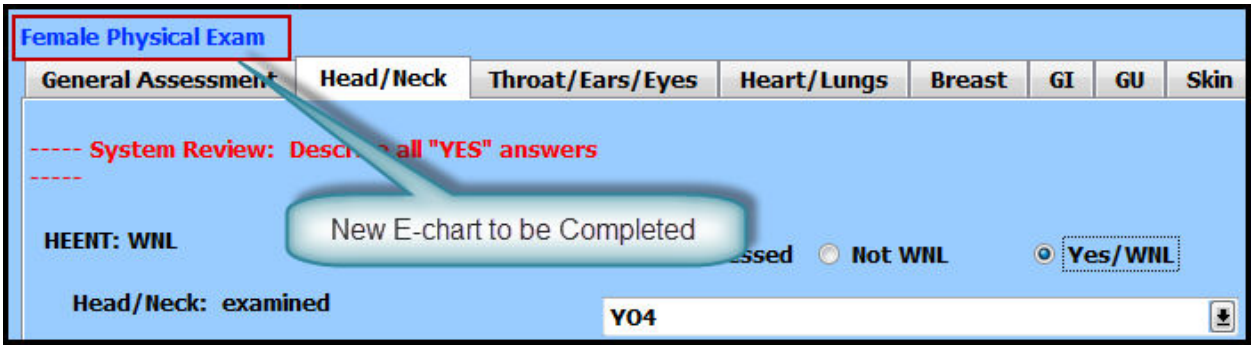
See System Administration Notes to set the flag

2. Accessing E charts from an encounter
    1. New message to allow user to review or create a new e-chart for the same type and same day if
        1. E-chart set up allows more than one version per day
        2. Original e-chart must be signed
        3. Affects e-charts created from the tool bar icon or the workflow
    2. Create an e-chart and sign
        1. Select the signed e-chart from the workflow. Check mark is green
        2. Message displays to Review Existing e-chart or Create a New e-chart

1. Select review: takes user to the signed e-chart
2. Select create a new: takes user to add new e-chart of this type if another one is allowed to be entered for the same day of service.





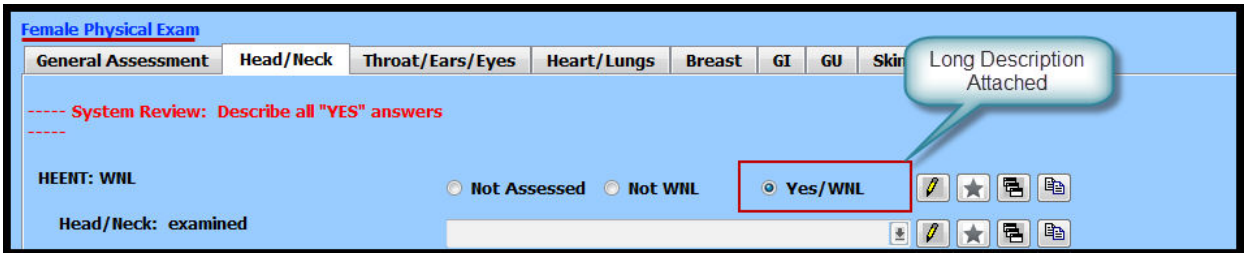


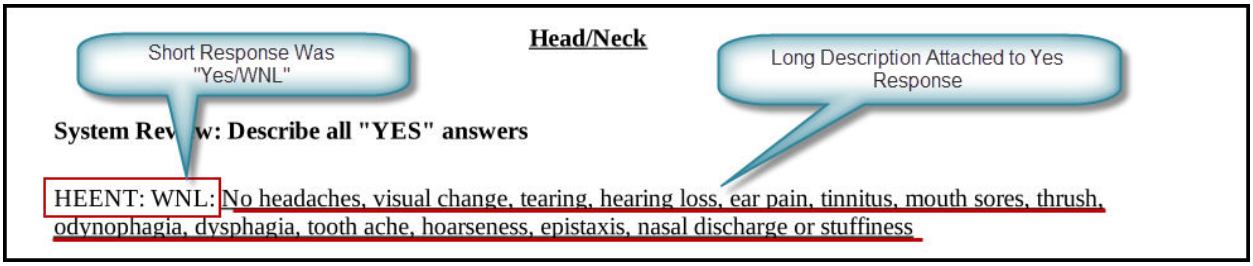
2. E-chart print out
   Printout for e-charts now contains on each page
   1. Patient's name
   2. Patient's number
   3. Date printed

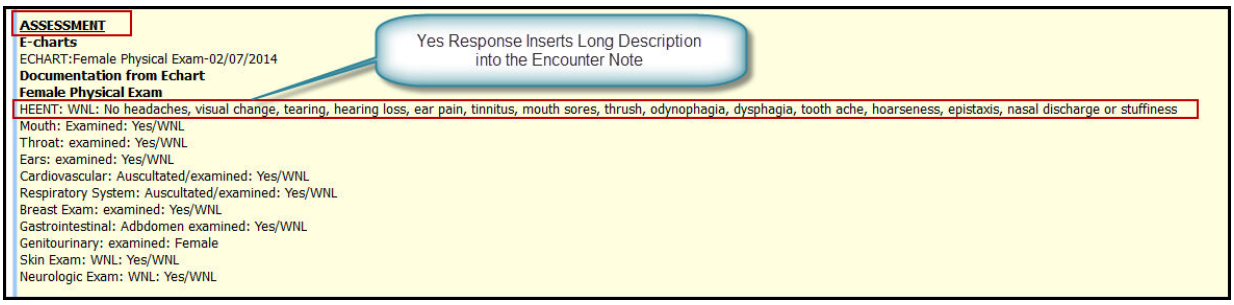
4. Page number
5. Total number of pages
6. Attribution of each item pulled forward and person response attributed to

See System Administration Notes for Long Descriptions and Insert into Encounter Note

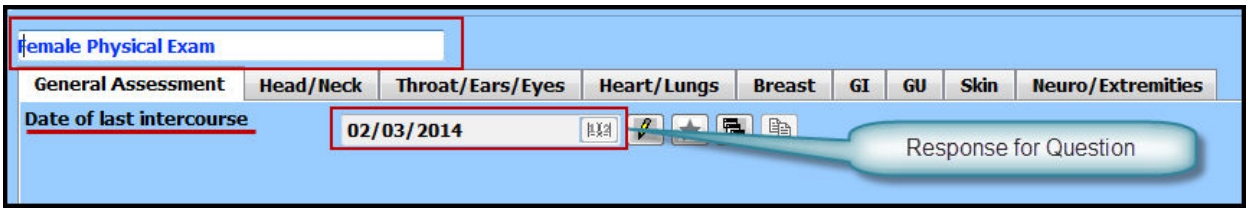
3. Long Descriptions
    1. Ability to have long text descriptions linked to e-chart responses
    2. Descriptions are for all users. Not unique to any one user
    3. Display
        1. Short description/Code displays on actual e-charting screen
        2. Long description linked to code displays on any printout and on encounter screen
    4. Linked to the following question types
        1. Radio buttons
        2. Checklists
        3. Lookups

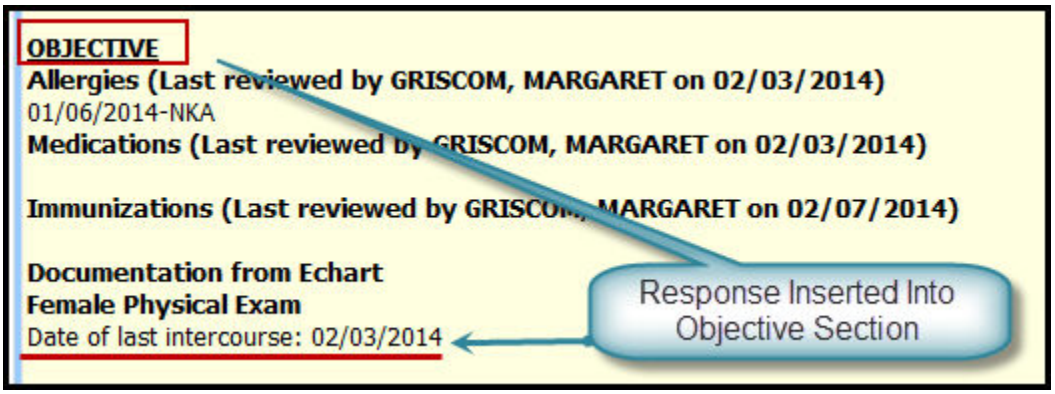


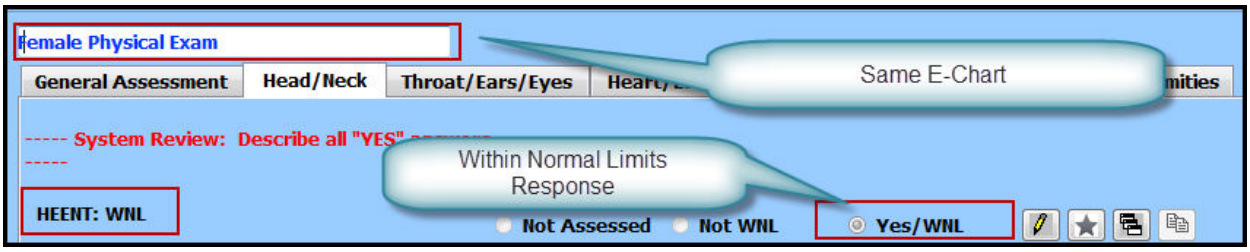

Head/Neck
Short Response Was "Yes/WNL"
Long Description Attached to Yes Response
System Rev w: Describe all "YES" answers
HEENT: WNL: No headaches, visual change, tearing, hearing loss, ear pain, tinnitus, mouth sores, thrush, odynophagia, dysphagia, tooth ache, hoarseness, epistaxis, nasal discharge or stuffiness

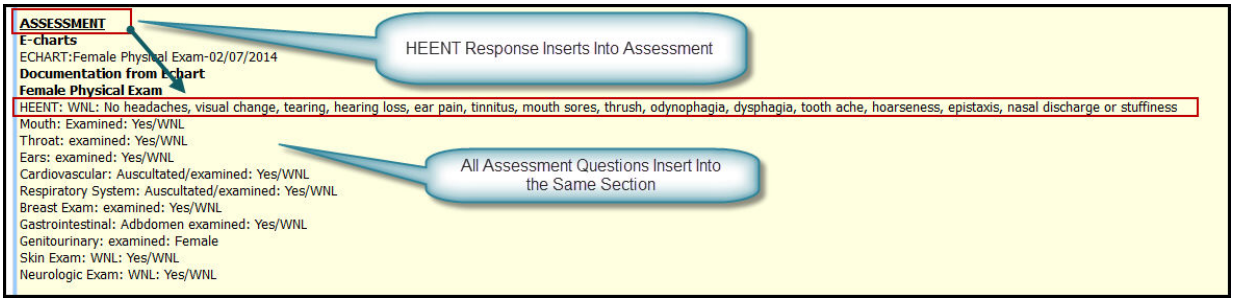

ASSESSMENT
E-charts
ECHART:Female Physical Exam-02/07/2014
Documentation from Echart
Female Physical Exam
HEENT: WNL: No headaches, visual change, tearing, hearing loss, ear pain, tinnitus, mouth sores, thrush, odynophagia, dysphagia, tooth ache, hoarseness, epistaxis, nasal discharge or stuffiness
Mouth: Examined: Yes/WNL
Throat: examined: Yes/WNL
Ears: examined: Yes/WNL
Cardiovascular: Auscultated/examined: Yes/WNL
Respiratory System: Auscultated/examined: Yes/WNL
Breast Exam: examined: Yes/WNL
Gastrointestinal: Adbdomen examined: Yes/WNL
Genitourinary: examined: Female
Skin Exam: WNL: Yes/WNL
Neurologic Exam: WNL: Yes/WNL
Yes Response Inserts Long Description into the Encounter Note

4. E-charting items insert into Encounter Note
    1. No longer have to drag and drop individual answers into the Encounter Note
    2. Different question types can be inserted into different sections of the Encounter Note
    3. Not unique to individual users.
        1. Questions insert into the same section of the note for all users
        2. Multiple questions can insert into each section
        3. Response can insert into only 1 section.




OBJECTIVE
Allergies (Last reviewed by GRISCOM, MARGARET on 02/03/2014)
01/06/2014-NKA
Medications (Last reviewed by GRISCOM, MARGARET on 02/03/2014)
Immunizations (Last reviewed by GRISCOM, MARGARET on 02/07/2014)
Documentation from Echart
Female Physical Exam
Date of last intercourse: 02/03/2014
Response Inserted Into Objective Section

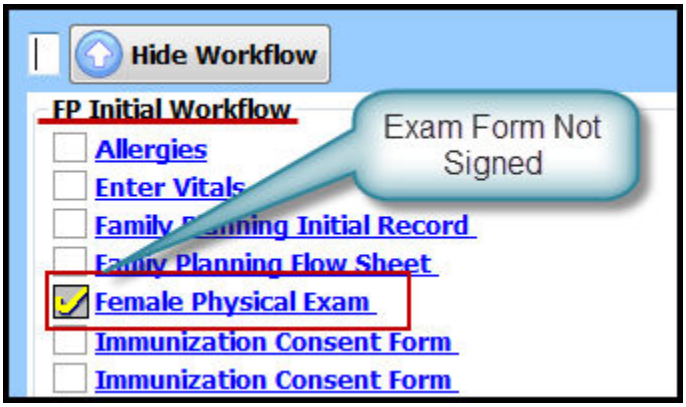


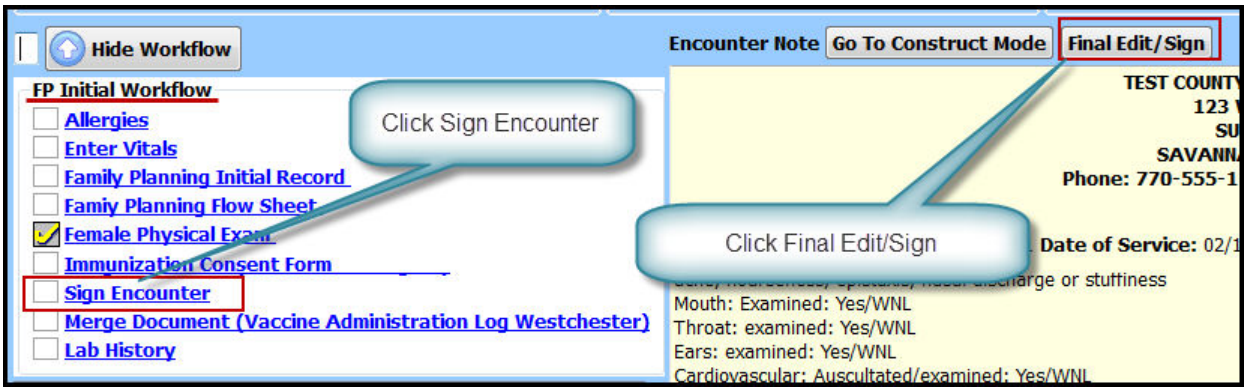

ASSESSMENT
E-charts
ECHART:Female Physical Exam-02/07/2014
Documentation from Echart
Female Physical Exam
HEENT: WNL: No headaches, visual change, tearing, hearing loss, ear pain, tinnitus, mouth sores, thrush, odynophagia, dysphagia, tooth ache, hoarseness, epistaxis, nasal discharge or stuffiness
Mouth: Examined: Yes/WNL
Throat: examined: Yes/WNL
Ears: examined: Yes/WNL
Cardiovascular: Auscultated/examined: Yes/WNL
Respiratory System: Auscultated/examined: Yes/WNL
Breast Exam: examined: Yes/WNL
Gastrointestinal: Adbdomen examined: Yes/WNL
Genitourinary: examined: Female
Skin Exam: WNL: Yes/WNL
Neurologic Exam: WNL: Yes/WNL
HEENT Response Inserts Into Assessment
All Assessment Questions Insert Into the Same Section

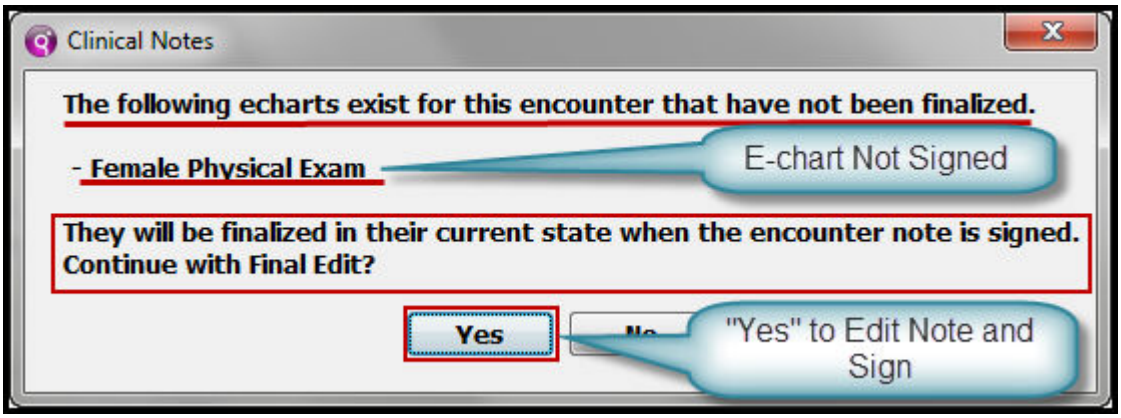
5. Unsigned e-charts
    1. New feature to sign e-charts as part of the encounter
        1. Limits unsigned e-charts
        2. Providers need one signature to sign Encounter Note and any e-charts linked to the encounter
        3. Previous e-charts not overwritten because were not signed.
    2. Optional feature
        1. Based on decision of the LHD
        2. Flag to be set by M&M
    3. User to access e-chart from Workflow
        1. Complete e-chart but do not sign
        2. Workflow item is checked in Yellow
        3. Complete encounter
        4. Choose Sign Encounter from the Workflow or Final Edit/Sign from the on the Encounter
            1. Message displays: E-charts not finalized
            2. Lists e-charts that have been started but not signed
            3. Allows user to choose to sign when sign the encounter

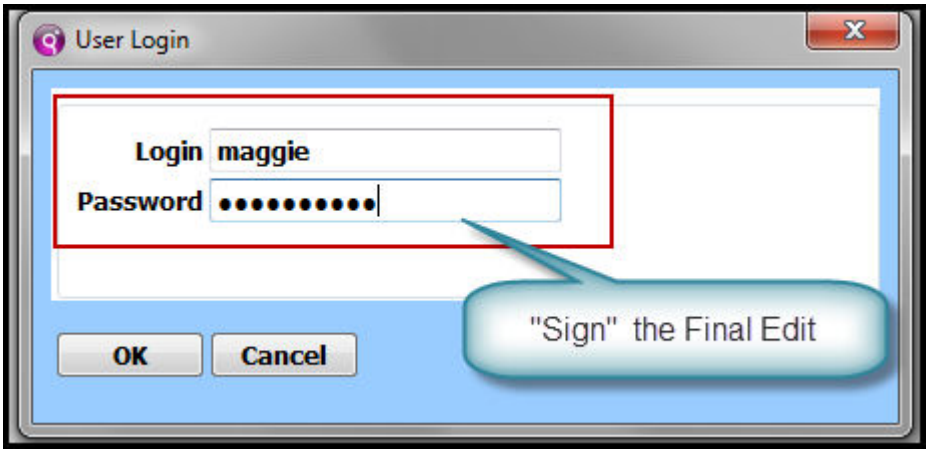
To have signature flag set to sign e-charts when encounters are signed

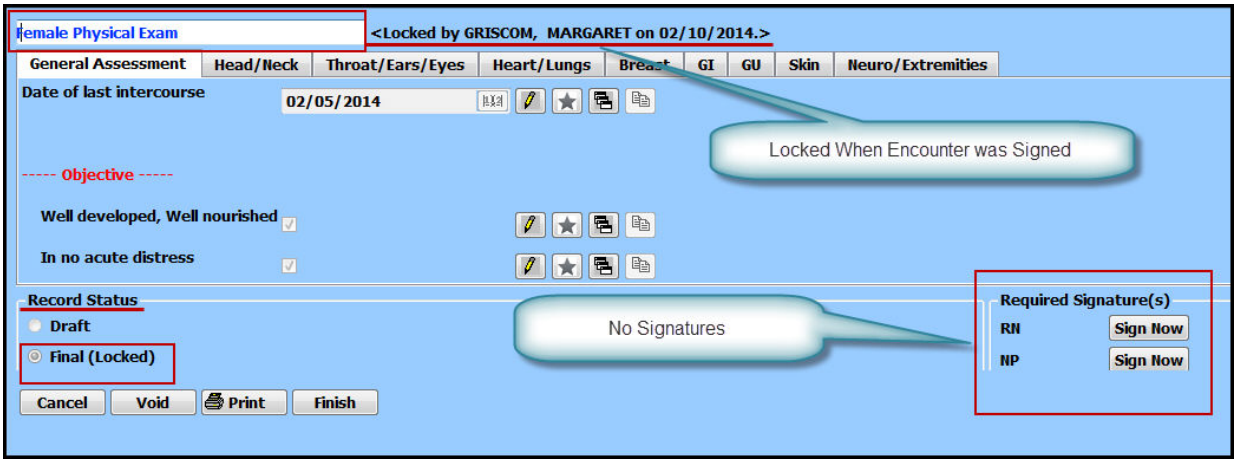
Please allow 7-10 working days for the flag to be set. M&M staff will notify System Administrators when the flag is set.


Hide Workflow
FP Initial Workflow
Allergies
Enter Vitals
Family Planning Initial Record
Family Planning Flow Sheet
Female Physical Exam
Immunization Consent Form
Immunization Consent Form
Exam Form Not Signed


Hide Workflow
FP Initial Workflow
Allergies
Enter Vitals
Family Planning Initial Record
Family Planning Flow Sheet
Female Physical Exam
Immunization Consent Form
Sign Encounter
Merge Document (Vaccine Administration Log Westchester)
Lab History
Click Sign Encounter
Encounter Note
Go To Construct Mode
Final Edit/Sign
Click Final Edit/Sign
Date of Service:
Mouth: Examined: Yes/WNL
Throat: examined: Yes/WNL
Ears: examined: Yes/WNL


Clinical Notes
The following echarts exist for this encounter that have not been finalized.
- Female Physical Exam
E-chart Not Signed
They will be finalized in their current state when the encounter note is signed.
Continue with Final Edit?
Yes
"Yes" to Edit Note and Sign


User Login
Login
maggie
Password
OK
Cancel
"Sign" the Final Edit


Female Physical Exam
<Locked by GRISCOM, MARGARET on 02/10/2014.>
General Assessment
Head/Neck
Throat/Ears/Eyes
Heart/Lungs
Breast
GI
GU
Skin
Neuro/Extremities
Date of last intercourse
02/05/2014
Locked When Encounter was Signed
----- Objective -----
Well developed, Well nourished
In no acute distress
Record Status
Draft
Final (Locked)
No Signatures
Required Signature(s)
RN
Sign Now
NP
Sign Now
Cancel
Void
Print
Finish

Lab Orders

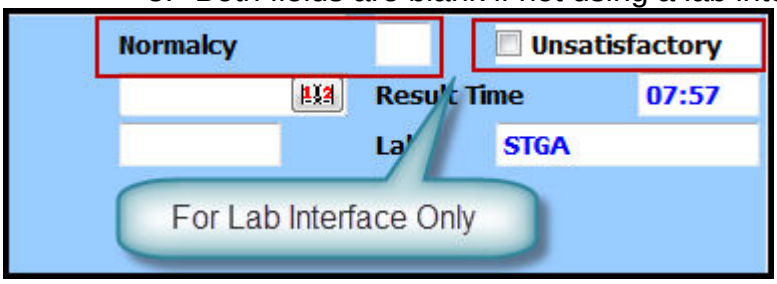
1. Comments added to Lab Orders
    1. Required for Lab Interfaces
2. Lab Orders/Collection Date
    1. New Error message user attempts to collect a lab for a future date
    2. User will no longer be able to collect the lab using a date in the future
    3. Includes test that are auto collected
    4. User must remove future Collection Date to exit screen

Lab Results

1. Collection Date added to lab results
    1. Allows user to identify specimens for the same test that were collected on separate dates.
        1. Example: Sputums collected over 3 days
        2. Use for labs that are ordered to repeat
            1. Order date is the same for all of the repeated labs
            2. Collection date now displays on Lab result screen
            3. Result can now be posted for the specimen collected on a specific date

2. Lab Result Comment Field
    1. Comments field
        1. Comments can be added manually if not using the lab interface
        2. Increase length to unlimited number of characters to accommodate the lab interface
        3. Added View Comment button to view long comments

3. Additional Fields to be used by **Lab Interface Only**
    1. Normalcy
    2. Unsatisfactory
    3. Both fields are blank if not using a lab interface



3. Lab Result
    1. When lab results are changed task list updated to indicate further review
        1. Lab re-inserts into task list for review
        2. Tab through the Review Now fields and previous date is removed
        3. Inserts the new result into the Review Lab Screen
        4. Process is automatic when lab result is changed. Example: from a preliminary result to the final result.

Medication Recommendations

1. ***1.*** Optional Feature ***Not turned on unless requested***
2. Needed for Stage II Meaningful Use

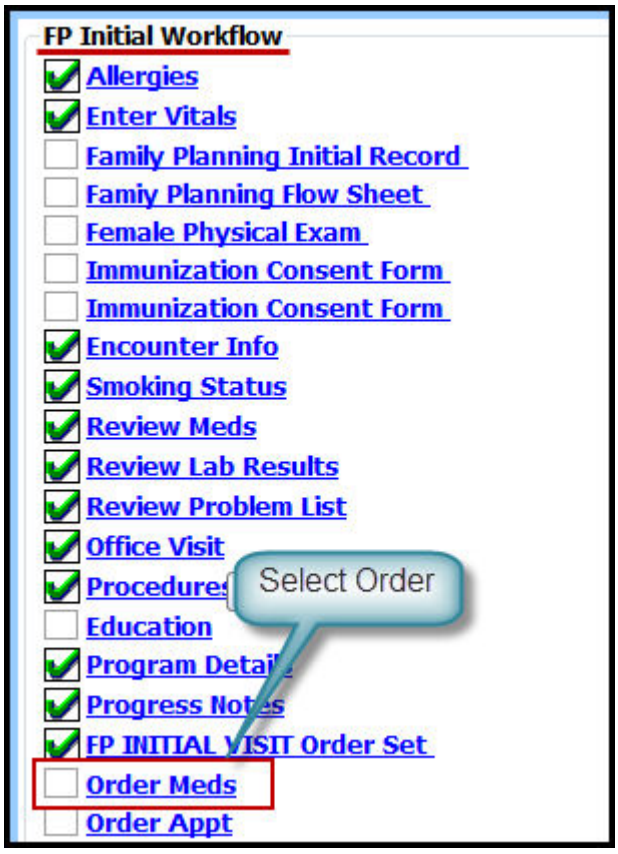
To have feature turned on. Please allow 5 - 7 business days for process to be completed.

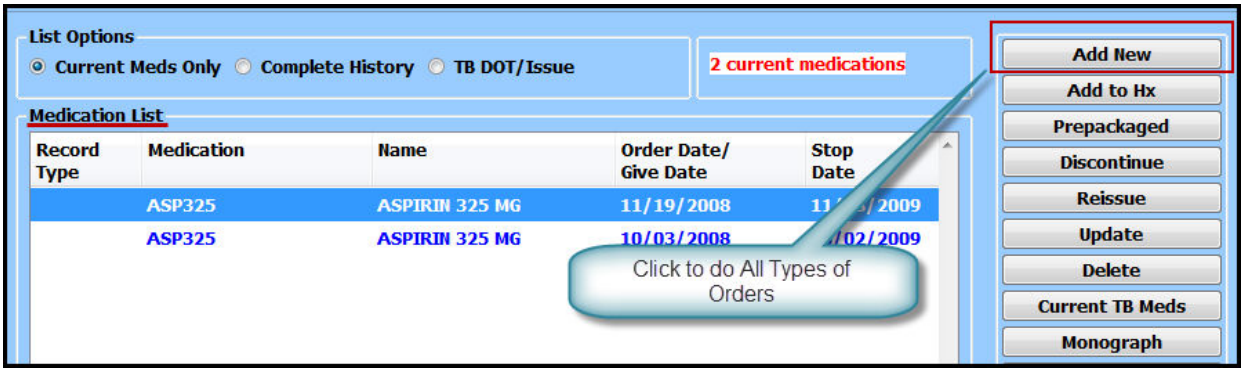
3. Features:
    1. One screen to select medication and type of order
    2. Can order medications
        1. In-house
        2. Outside
        3. E-Prescribing
    3. Medication recommendations display based on ***diagnosis codes***
        1. List condition(s) that are related
        2. Displays list of medications to be ordered
        3. Builds a Frequently Used List based on the User's Preferences
    4. Restrict searches based on
        1. All filters default to ALL
        2. Medication Name or Source
            1. Package Product Name
            2. Generic Name
            3. Generically Named Packaged Product
            4. Unassociated
            5. All name sources
        3. Management of
            1. Problem
            2. Related Conditions
            3. All of the above
        4. FDA Label
            1. FDA - Approved
            2. Unlabeled
            3. All the above
        5. Inventory
            1. Inside
            2. Outside
            3. All of the above
    5. Runs allergy, duplicate therapy and drug-drug interactions
    6. New order screen
        1. Orders insert based on the Recommendations chosen
        2. User completes the:

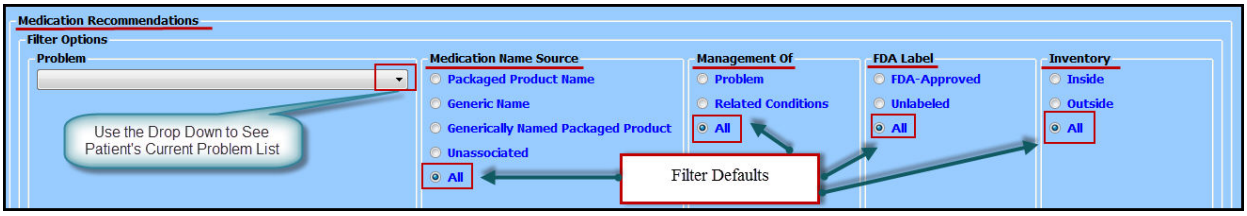
1. Amount ordered
2. # of refills
3. Sig code/directions

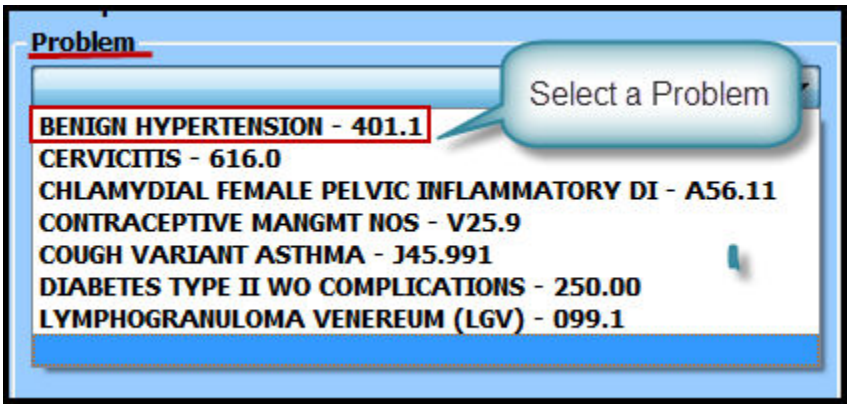
7. Function
    1. Complete the Clinical Encounter
        1. Allergies
        2. Drug history
        3. Problem list
    2. Select Order Meds from the workflow
        1. At Medication screen select Add New
        2. New screen displays
    3. Select a problem from the Problem Option
        1. Presents only the patient's current Problem List
        2. Drop down for patient's with multiple problems
    4. Problem and any related problem types displays in the Condition Related grid
        1. Active Problem from the Problem List displays first
        2. Highlight related Problem to change the Medication Recommendation
    5. Recommended medications display
        1. Defaults to Frequently Used
            1. Sorts by percentage of encounters it is used for.
            2. Check the box to select the medication
        2. Click the tab with the Diagnosis to see all drugs recommended for this condition.
            1. Check the medication to order
            2. Medication inserts into Selected Medications
        3. To shorten a long list of medications
            1. Search function at bottom of the screen
            2. Works as a zoom feature
            3. Start typing the medication needed and the list will shorten
    6. Selected Medications
        1. Displays multiple medications at once
        2. User can see all medications ordered at one time
        3. Can remove and order another medication before completing the medication order
    7. Click OK for Medication Orders screen to display
        1. List all of the selected medications
        2. Tab to the Quantity Prescribed field enter the amount here
        3. Enter the Number of Refills
        4. Enter the Direction Code to add the directions
        5. Select Fill Method
            1. In-house
            2. Outside
            3. E-prescribe

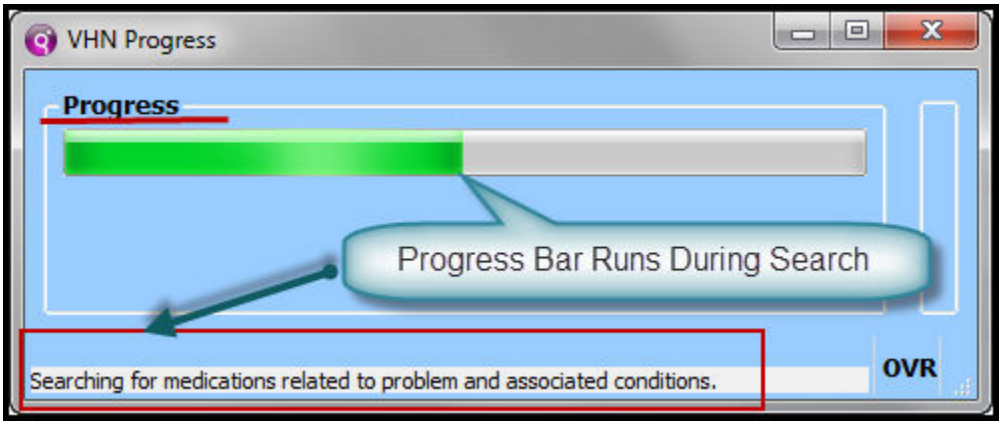
4. Function as before
6. Complete each medication ordered
8. Click OK for interactions to run
    1. Drug-Allergies
    2. Drug-Drug
    3. Duplicate Therapy
    4. Approve/Disapprove Interaction Alerts

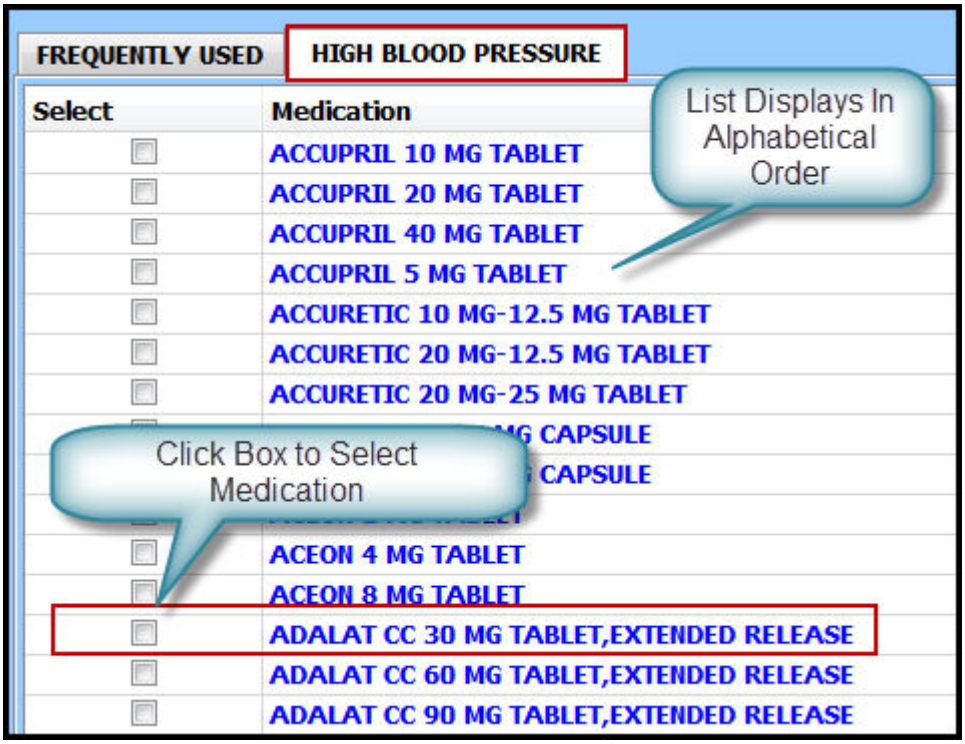


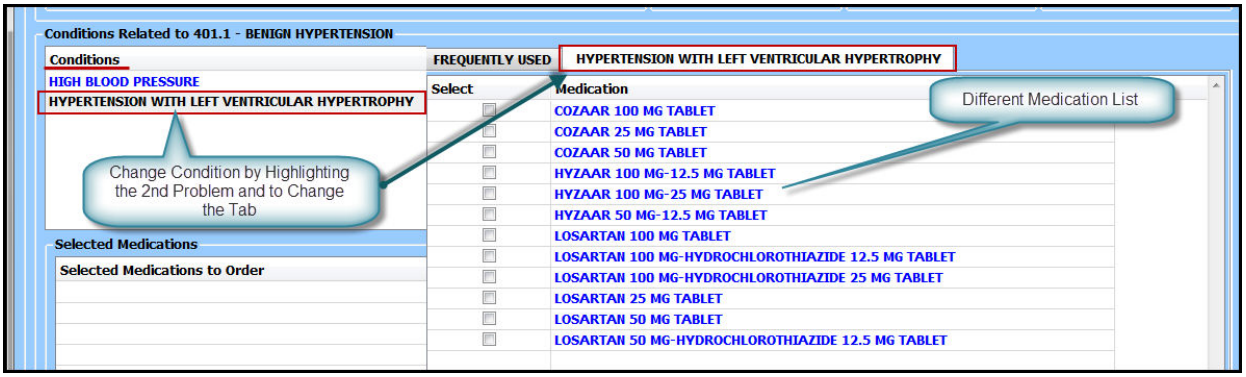


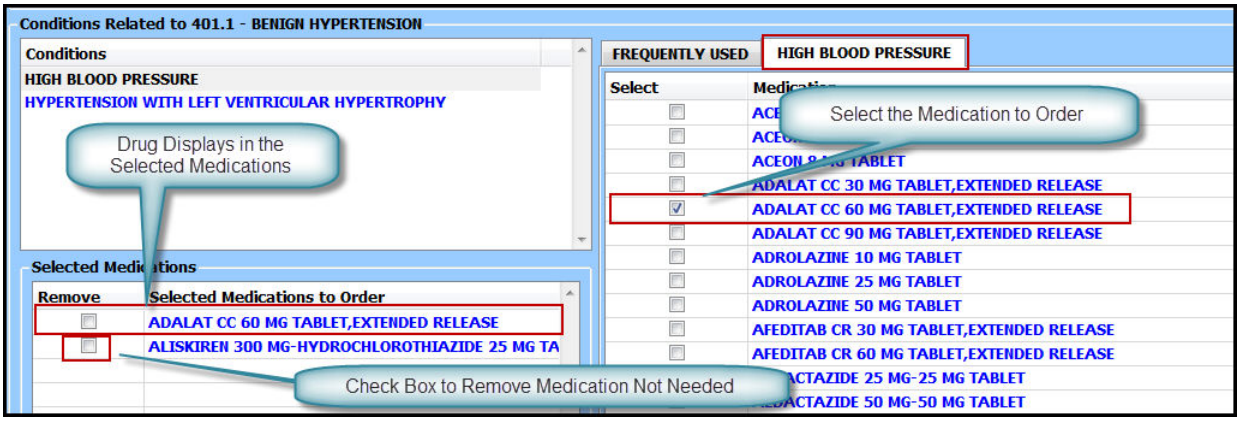

Medication Recommendations
Filter Options
Problem
Use the Drop Down to See Patient's Current Problem List
Medication Name Source
Packaged Product Name
Generic Name
Generically Named Packaged Product
Unassociated
All
Management Of
Problem
Related Conditions
All
FDA Label
FDA-Approved
Unlabeled
All
Inventory
Inside
Outside
All
Filter Defaults


Problem
Select a Problem
BENIGN HYPERTENSION - 401.1
CERVICITIS - 616.0
CHLAMYDIAL FEMALE PELVIC INFLAMMATORY DI - A56.11
CONTRACEPTIVE MANGMT NOS - V25.9
COUGH VARIANT ASTHMA - J45.991
DIABETES TYPE II WO COMPLICATIONS - 250.00
LYMPHOGRANULOMA VENEREUM (LGV) - 099.1

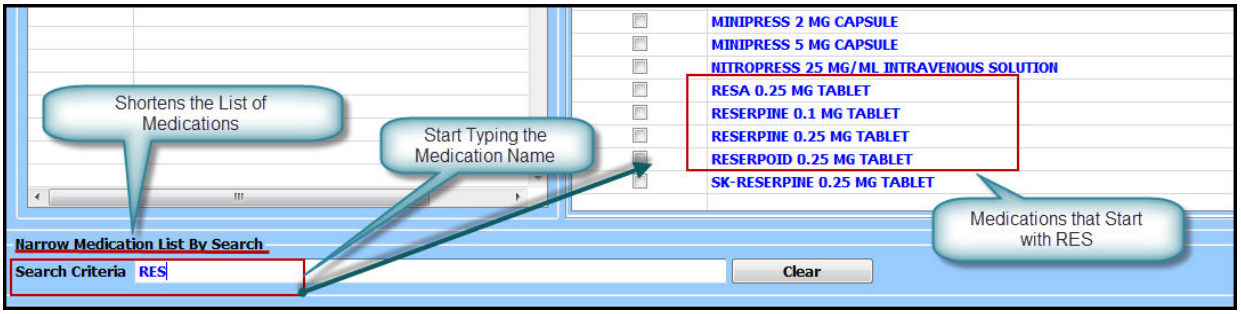

VHN Progress
Progress
Progress Bar Runs During Search
Searching for medications related to problem and associated conditions.
OVR

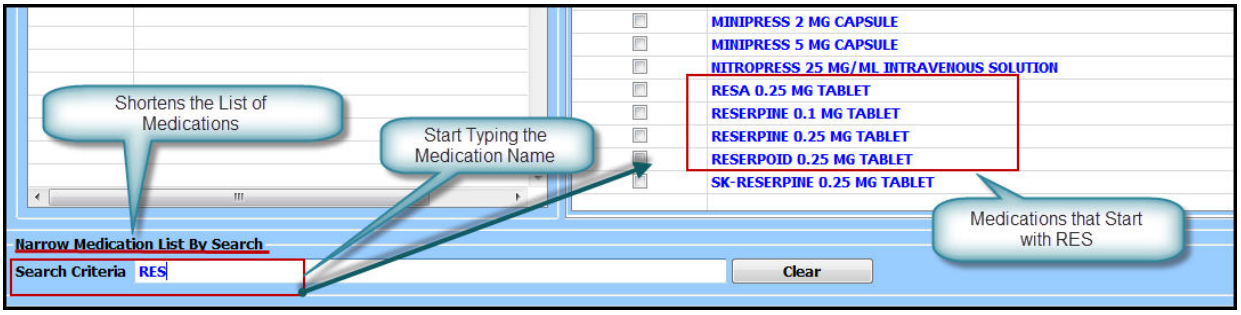

FREQUENTLY USED
HIGH BLOOD PRESSURE
Select
Medication
List Displays In Alphabetical Order
ACCUPRIL 10 MG TABLET
ACCUPRIL 20 MG TABLET
ACCUPRIL 40 MG TABLET
ACCUPRIL 5 MG TABLET
ACCURETIC 10 MG-12.5 MG TABLET
ACCURETIC 20 MG-12.5 MG TABLET
ACCURETIC 20 MG-25 MG TABLET
Click Box to Select Medication
ACEON 4 MG TABLET
ACEON 8 MG TABLET
ADALAT CC 30 MG TABLET,EXTENDED RELEASE
ADALAT CC 60 MG TABLET,EXTENDED RELEASE
ADALAT CC 90 MG TABLET,EXTENDED RELEASE

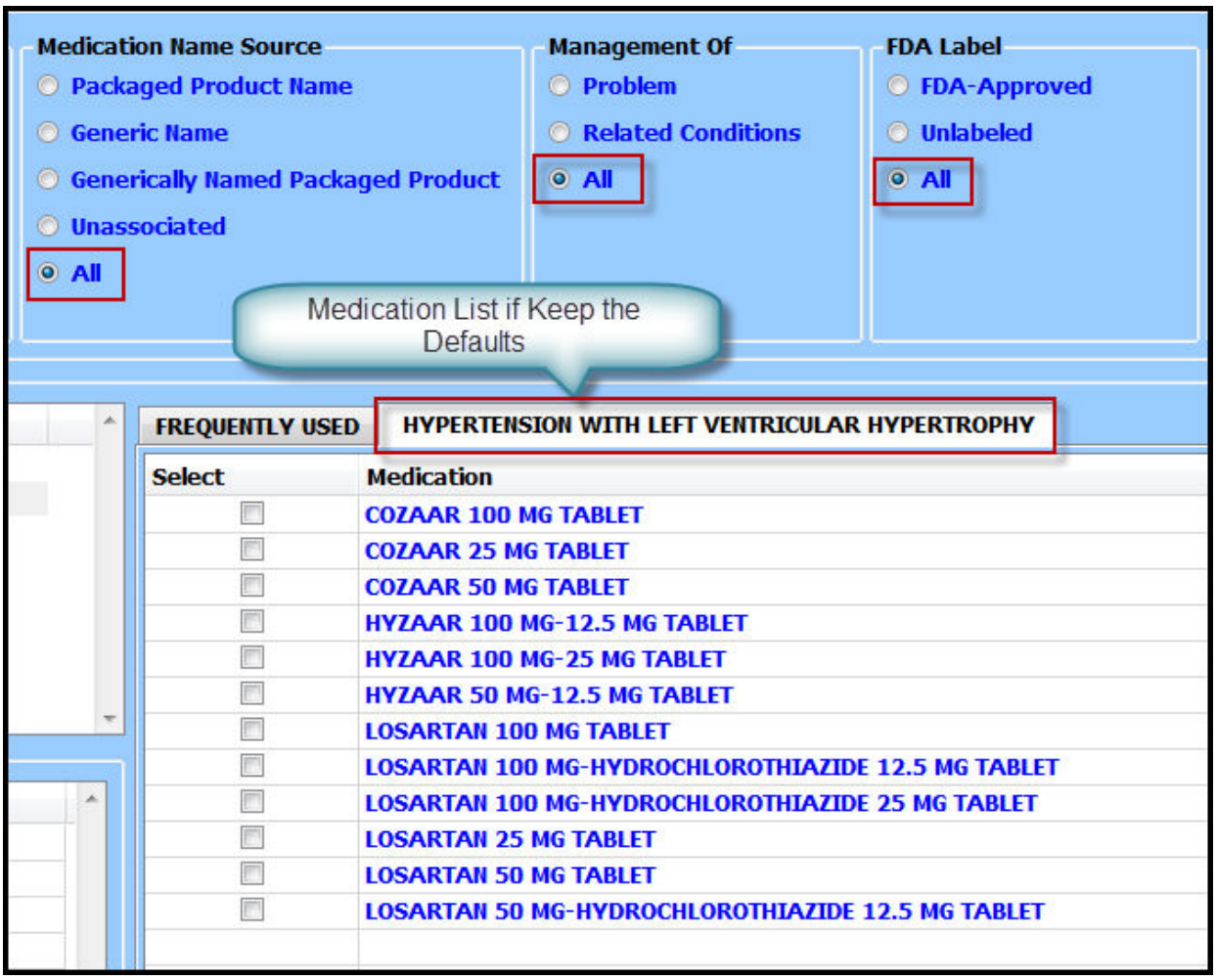

Conditions Related to 401.1 - BENIGN HYPERTENSION
Conditions
HIGH BLOOD PRESSURE
HYPERTENSION WITH LEFT VENTRICULAR HYPERTROPHY
Change Condition by Highlighting the 2nd Problem and to Change the Tab
FREQUENTLY USED
HYPERTENSION WITH LEFT VENTRICULAR HYPERTROPHY
Select
Medication
Different Medication List
COZAAR 100 MG TABLET
COZAAR 25 MG TABLET
COZAAR 50 MG TABLET
HYZAAR 100 MG-12.5 MG TABLET
HYZAAR 100 MG-25 MG TABLET
HYZAAR 50 MG-12.5 MG TABLET
LOSARTAN 100 MG TABLET
LOSARTAN 100 MG-HYDROCHLOROTHIAZIDE 12.5 MG TABLET
LOSARTAN 100 MG-HYDROCHLOROTHIAZIDE 25 MG TABLET
LOSARTAN 25 MG TABLET
LOSARTAN 50 MG TABLET
LOSARTAN 50 MG-HYDROCHLOROTHIAZIDE 12.5 MG TABLET
Selected Medications
Selected Medications to Order

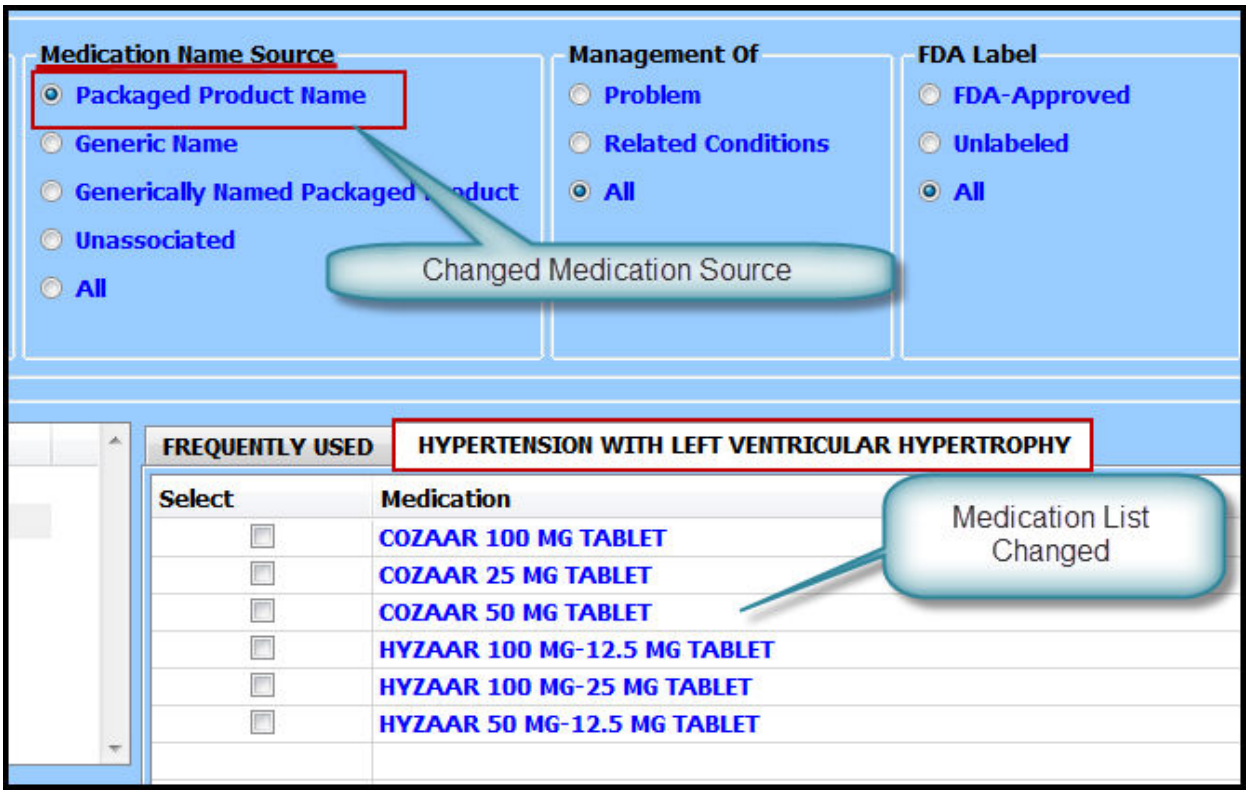

Conditions Related to 401.1 - BENIGN HYPERTENSION
Conditions
HIGH BLOOD PRESSURE
HYPERTENSION WITH LEFT VENTRICULAR HYPERTROPHY
Drug Displays in the Selected Medications
FREQUENTLY USED
HIGH BLOOD PRESSURE
Select
Select the Medication to Order
ADALAT CC 30 MG TABLET,EXTENDED RELEASE
ADALAT CC 60 MG TABLET,EXTENDED RELEASE
ADALAT CC 90 MG TABLET,EXTENDED RELEASE
ADROLAZINE 10 MG TABLET
ADROLAZINE 25 MG TABLET
ADROLAZINE 50 MG TABLET
AFEDITAB CR 30 MG TABLET,EXTENDED RELEASE
AFEDITAB CR 60 MG TABLET,EXTENDED RELEASE
Remove
Selected Medications to Order
ADALAT CC 60 MG TABLET,EXTENDED RELEASE
ALISKIREN 300 MG-HYDROCHLOROTHIAZIDE 25 MG TA
Check Box to Remove Medication Not Needed

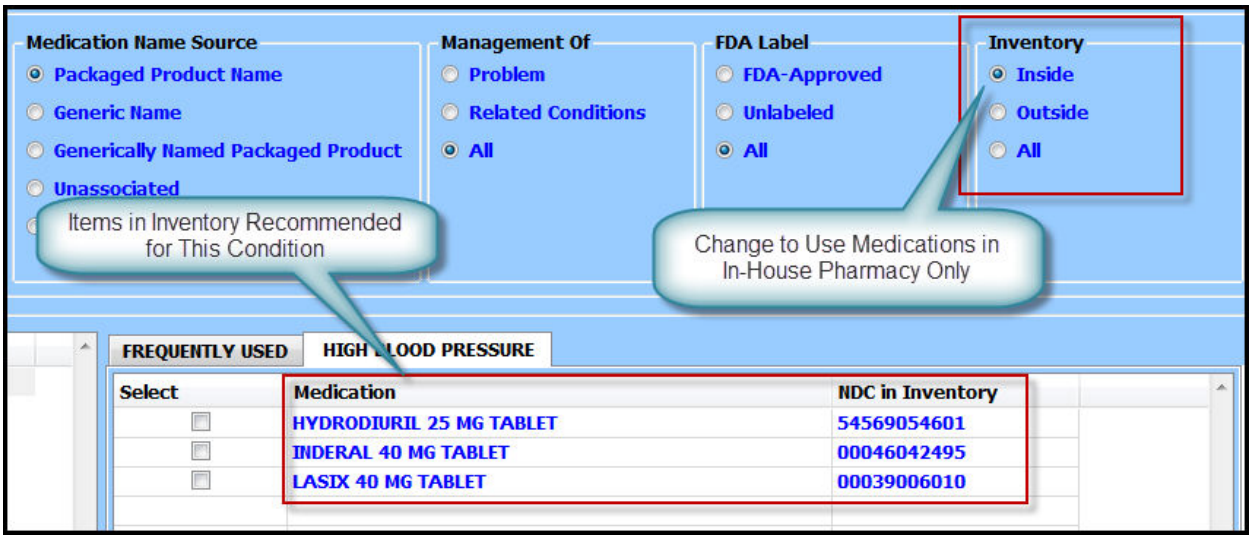
Selected Medications
Remove
Selected Medications to Order
ADALAT CC 60 MG TABLET,EXTENDED RELEASE
Medication Removed

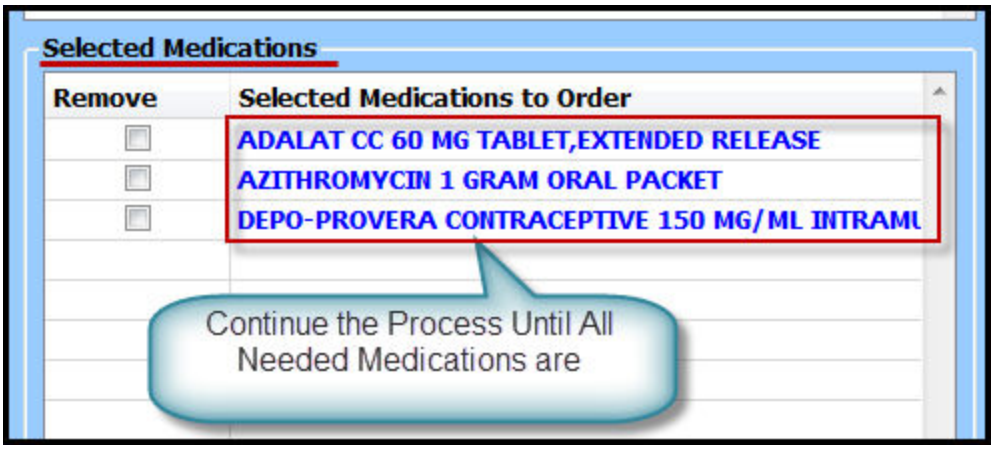

MINIPRESS 2 MG CAPSULE
MINIPRESS 5 MG CAPSULE
NITROPRESS 25 MG/ML INTRAVENOUS SOLUTION
RESA 0.25 MG TABLET
RESERPINE 0.1 MG TABLET
RESERPINE 0.25 MG TABLET
RESERPOID 0.25 MG TABLET
SK-RESERPINE 0.25 MG TABLET
Shortens the List of Medications
Start Typing the Medication Name
Medications that Start with RES
Narrow Medication List By Search
Search Criteria RES
Clear

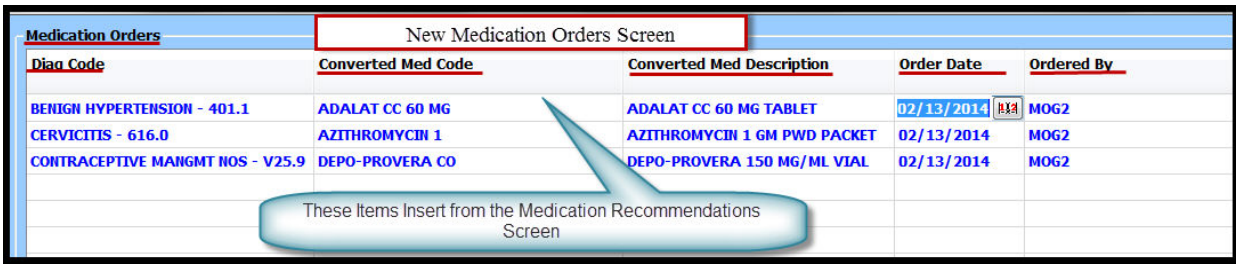

MINIPRESS 2 MG CAPSULE
MINIPRESS 5 MG CAPSULE
NITROPRESS 25 MG/ML INTRAVENOUS SOLUTION
RESA 0.25 MG TABLET
RESERPINE 0.1 MG TABLET
RESERPINE 0.25 MG TABLET
RESERPOID 0.25 MG TABLET
SK-RESERPINE 0.25 MG TABLET
Shortens the List of Medications
Start Typing the Medication Name
Medications that Start with RES
Narrow Medication List By Search
Search Criteria RES
Clear

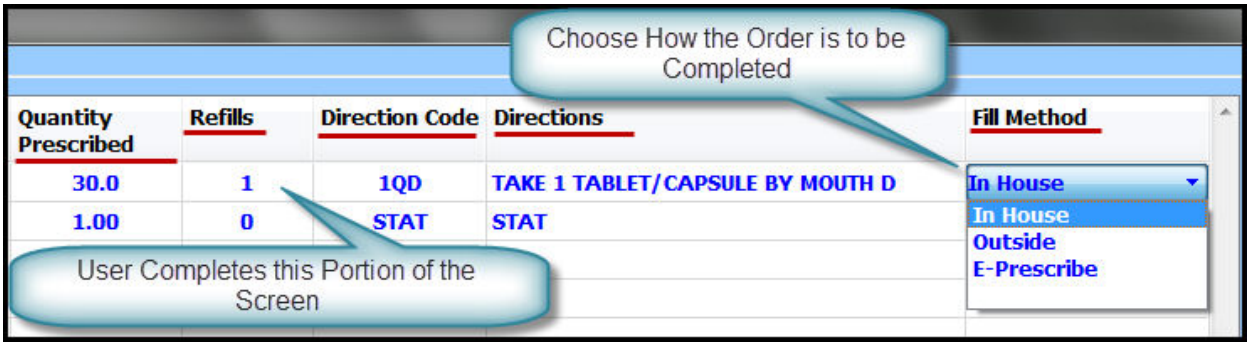

Medication Name Source
Packaged Product Name
Generic Name
Generically Named Packaged Product
Unassociated
All
Management Of
Problem
Related Conditions
All
FDA Label
FDA-Approved
Unlabeled
All
Medication List if Keep the Defaults
FREQUENTLY USED
HYPERTENSION WITH LEFT VENTRICULAR HYPERTROPHY
Select
Medication
COZAAR 100 MG TABLET
COZAAR 25 MG TABLET
COZAAR 50 MG TABLET
HYZAAR 100 MG-12.5 MG TABLET
HYZAAR 100 MG-25 MG TABLET
HYZAAR 50 MG-12.5 MG TABLET
LOSARTAN 100 MG TABLET
LOSARTAN 100 MG-HYDROCHLOROTHIAZIDE 12.5 MG TABLET
LOSARTAN 100 MG-HYDROCHLOROTHIAZIDE 25 MG TABLET
LOSARTAN 25 MG TABLET
LOSARTAN 50 MG TABLET
LOSARTAN 50 MG-HYDROCHLOROTHIAZIDE 12.5 MG TABLET

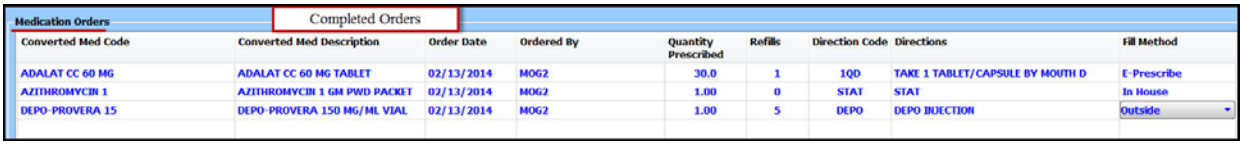

Medication Name Source
Packaged Product Name
Generic Name
Generically Named Packaged Product
Unassociated
All
Management Of
Problem
Related Conditions
All
FDA Label
FDA-Approved
Unlabeled
All
Changed Medication Source
FREQUENTLY USED
HYPERTENSION WITH LEFT VENTRICULAR HYPERTROPHY
Select
Medication
COZAAR 100 MG TABLET
COZAAR 25 MG TABLET
COZAAR 50 MG TABLET
HYZAAR 100 MG-12.5 MG TABLET
HYZAAR 100 MG-25 MG TABLET
HYZAAR 50 MG-12.5 MG TABLET
Medication List Changed


Medication Name Source
Packaged Product Name
Generic Name
Generically Named Packaged Product
Unassociated
Management Of
Problem
Related Conditions
All
FDA Label
FDA-Approved
Unlabeled
All
Inventory
Inside
Outside
All
Items in Inventory Recommended for This Condition
Change to Use Medications in In-House Pharmacy Only
FREQUENTLY USED
HIGH BLOOD PRESSURE
Select
Medication
NDC in Inventory
HYDRODIURIL 25 MG TABLET
54569054601
INDERAL 40 MG TABLET
00046042495
LASIX 40 MG TABLET
00039006010


Selected Medications
Remove
Selected Medications to Order
ADALAT CC 60 MG TABLET,EXTENDED RELEASE
AZITHROMYCIN 1 GRAM ORAL PACKET
DEPO-PROVERA CONTRACEPTIVE 150 MG/ML INTRAMU
Continue the Process Until All Needed Medications are


Medication Orders
New Medication Orders Screen
Diag Code
Converted Med Code
Converted Med Description
Order Date
Ordered By
BENIGN HYPERTENSION - 401.1
ADALAT CC 60 MG
ADALAT CC 60 MG TABLET
02/13/2014
MOG2
CERVICITIS - 616.0
AZITHROMYCIN 1
AZITHROMYCIN 1 GM PWD PACKET
02/13/2014
MOG2
CONTRACEPTIVE MANGMT NOS - V25.9
DEPO-PROVERA CO
DEPO-PROVERA 150 MG/ML VIAL
02/13/2014
MOG2
These Items Insert from the Medication Recommendations Screen


Choose How the Order is to be Completed
Quantity Prescribed
Refills
Direction Code
Directions
Fill Method
30.0
1
1QD
TAKE 1 TABLET/CAPSULE BY MOUTH D
In House
1.00
0
STAT
STAT
In House
Outside
E-Prescribe
User Completes this Portion of the Screen


Medication Orders
Completed Orders
Converted Med Code
Converted Med Description
Order Date
Ordered By
Quantity Prescribed
Refills
Direction Code
Directions
Fill Method
ADALAT CC 60 MG
ADALAT CC 60 MG TABLET
02/13/2014
MOG2
30.0
1
1QD
TAKE 1 TABLET/CAPSULE BY MOUTH D
E-Prescribe
AZITHROMYCIN 1
AZITHROMYCIN 1 GM PWD PACKET
02/13/2014
MOG2
1.00
0
STAT
STAT
In House
DEPO-PROVERA 15
DEPO-PROVERA 150 MG/ML VIAL
02/13/2014
MOG2
1.00
5
DEPO
DEPO INJECTION
Outside

Medication Screen

1. Change to the Output (Print) of the screen
    1. Stop Date changed to indicate Stopped or Expired
    2. Change to avoid confusion of why medication was stopped.
    3. Choose Output from the Medication List

2. Directions look up changes
    1. Functions when ordering medications and when doing Add to History
        1. Allows expanded Directions field to allow users to enter detailed directions
        2. Directions (Sig) search expanded to find all directions with the word anywhere in the directions. In the drop down to use the smart zoom function, the user can also type the word and it will find the directions with that word in it NOT JUST at the start of the line.
        3. List expanded to allow 2000 direction code entries.
        4. List no longer includes items that have been expired.
    2. Move to the Sig Code field. Accessed from:
        1. Medication History
        2. Dispensing Screen
        3. In-house/Outside Orders
    3. Enter a word/amount found in the Directions. Can not use special characters in search.
    4. The Directions Codes that include that word/amount will display. If user uses the drop down button to do the search with a smart zoom, it will also narrow down the list if the word is found anywhere in the directions
    5. Select the needed direction.
    6. Direction inserts into the Direction field on the screen

Patient Summary Screen

1. Alerts
    1. Beginning and Ending dates added to display
        1. Allows users to track items that need to be repeated
        2. Items continue to display only during the date range.

2. Authorize screen
    1. Access to the authorization screen added to Patient Summary
        1. Allows clinical staff to view Authorizations and Authorization Log
        2. Allows clinical staff to add new authorizations for release of records
    2. Click Authorization menu option

See User's Manual for instructions regarding the Authorization Screen

3. Lab Results Display
    1. Changes analyte descriptions now display instead of analyte codes
        1. Has more meaning for end users
        2. Some analyte codes are not representative of the actual result code

See VHN Maintenance Manual re: Lab Maintenance to create/change analyte descriptions if needed

4. Primary Care Provider
    1. Added field to display the patient's outside provider
    2. Defaults from Patient Central Registry

Referrals

1. Allows users to cycle through screen without having to cancel or OK
    1. Make corrections
    2. Complete fields that were missed during initial add.
2. Access the referral screen
    1. Add/Update depending on if processing from an order
    2. Tab through fields entering data
    3. At the bottom of the page the cursor returns to the top of the screen to allow for corrections or further additions

School Based Vision and Hearing

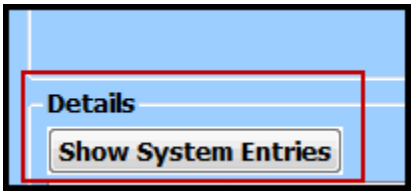
1. Output button added to menu
    1. Added to the Follow-up screen menu
    2. Available from both Vision and Hearing Follow-up screens
    3. Access the Follow-up screen from the Vision or Hearing Screening
        1. Click output
        2. Prints Follow-up form

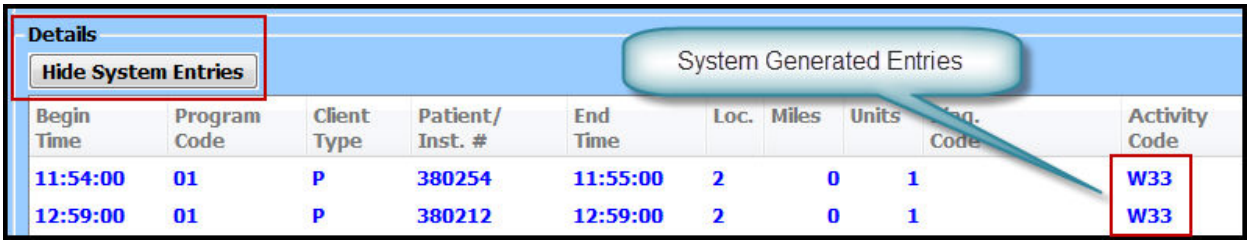
TB Medications

1. Change to the labels on the TB medication screens
    1. Units label now reads Doses/Visit
    2. Changed for clarification

Time and Activity Screen

1. New button added to Time and Activity Screen to allow for the filtering out of System Generated Time and Activity codes





    1. Allows users to view System Generated Items
    2. System adds each day automatically when a workflow item is checked
    3. Items inserted from Workflow activities
        1. Only inserts Workflow items with assigned Time and Activity Codes
        2. Inserts time as hh:mm:ss
        3. Location is generated as a 2 for the Health Department
        4. Inserts only Activity Codes. Does NOT generate billing codes
        5. System generates a W33 code to intake the creation of the Encounter.

1. Not a Workflow Item
2. Code loaded with release
3. Inserts automatically

6. Does not activate error message if System Generated item time overlaps a User added item

2. Default screen display is User added entries
3. Time display now in hh:mm:ss
    1. User adds the hour and minutes
    2. Seconds insert as 00 when user adds an item to the screen
4. For users that do both workflows and user entered items:
    1. If an item from a workflow is done prior to a user added item
        1. User Queries their provider code
        2. Screen defaults to User entered screen
            1. Update
            2. Move to a blank line and enter the time
            3. Complete entry as before.
    2. If an item is entered by the User before doing a workflow
        1. Access the Time and Activity screen
        2. Screen defaults to User entry screen
            1. Click Add
            2. Enter the provider code and date
            3. Enter the item into the first line
            4. Click OK when complete

3. To view System Generated items
    1. Query the user by provider code
    2. Enter a date
    3. Click the Show System Entries button
    4. Cannot add items to this screen
    5. Click Hide System Entries to view User added items or to insert more items directly into the screen.

4. Reports
    1. Parameter added to Time and Activity Reports to Include System Generated Items
        1. To Include: Enter "YES" at Include System Generated Entries
        2. To Exclude: Enter "NO" at Include System Generated Entries

TST Card

1. Additions to printing of TST results Card
    1. Added the MM to the result
    2. Now reads Positive/Negative (__MM)
        1. Enter TST results
        2. Click menu option Card
        3. Card/form will print

Vital Signs

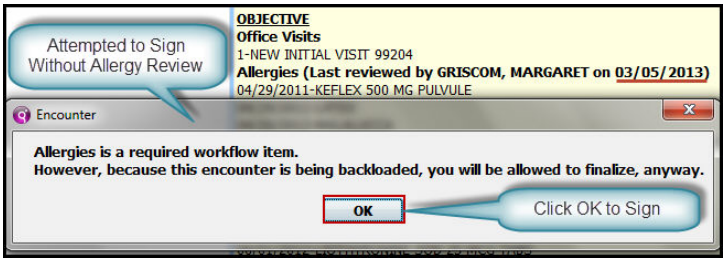
1. Print feature
    1. The print out for vitals sign realigned to make print out easier to read
    2. Added BMI
    3. Added Physical Activity Minutes/Week

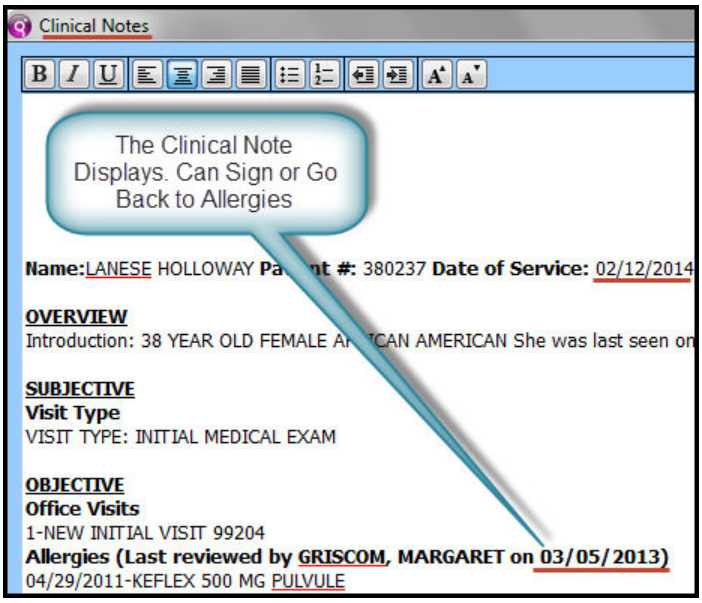
Workflows

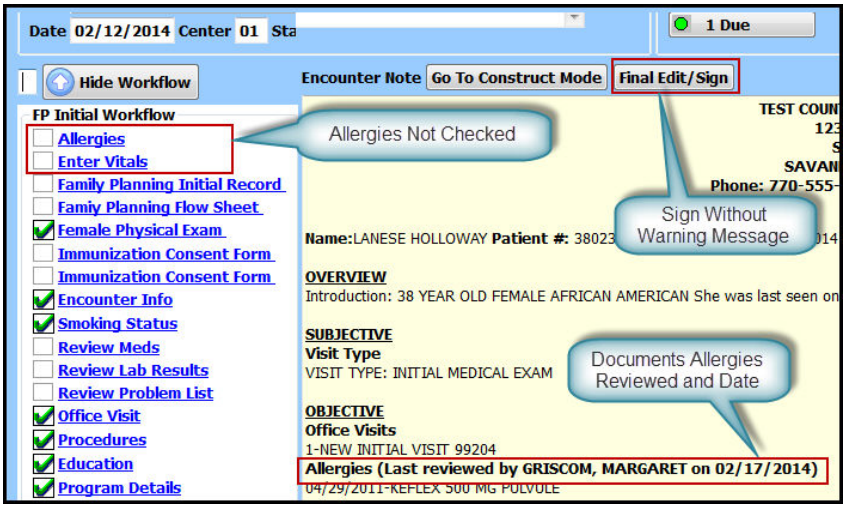
1. Encounter workflow indication
    1. Allows user to view workflow used for a specific encounter
    2. Workflow picked from the Choose Workflow list.
        1. Display with encounter
        2. User leaves encounter and opens again
        3. Opens with the workflow that has been used for the current encounter.

2. Backdated Encounters

    1. For items indicated as required to complete the encounter
        1. The item will not check off
        2. User will receive a warning that required items are not completed
    2. Required items continue to check off for encounters for current date


Attempted to Sign Without Allergy Review
OBJECTIVE
Office Visits
1-NEW INITIAL VISIT 99204
Allergies (Last reviewed by GRISCOM, MARGARET on 03/05/2013)
04/29/2011-KEFLEX 500 MG PULVULE
Encounter
Allergies is a required workflow item.
However, because this encounter is being backloaded, you will be allowed to finalize, anyway.
OK
Click OK to Sign


Clinical Notes
The Clinical Note Displays. Can Sign or Go Back to Allergies
Name:LANESE HOLLOWAY Patient #: 380237 Date of Service: 02/12/2014
OVERVIEW
Introduction: 38 YEAR OLD FEMALE AFRICAN AMERICAN She was last seen on
SUBJECTIVE
Visit Type
VISIT TYPE: INITIAL MEDICAL EXAM
OBJECTIVE
Office Visits
1-NEW INITIAL VISIT 99204
Allergies (Last reviewed by GRISCOM, MARGARET on 03/05/2013)
04/29/2011-KEFLEX 500 MG PULVULE



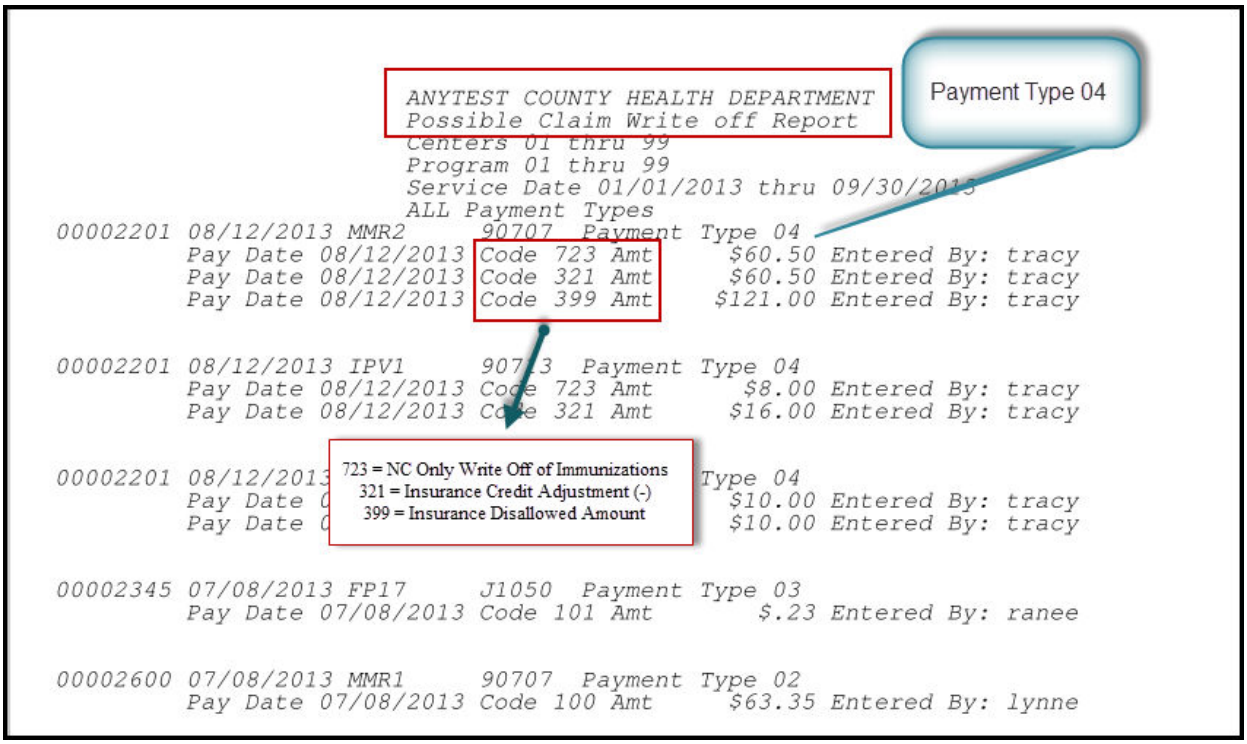
Reports

Billing Reports

1. Adjustment Write-off
    1. Indicates if a charge has been completely adjust off
    2. List the service date, program, center and payment type
    3. Enter report parameters
        1. Beginning and Ending Service Dates
        2. Beginning and Ending Centers
        3. Beginning and Ending Programs
        4. Payment Type: the default is A for All

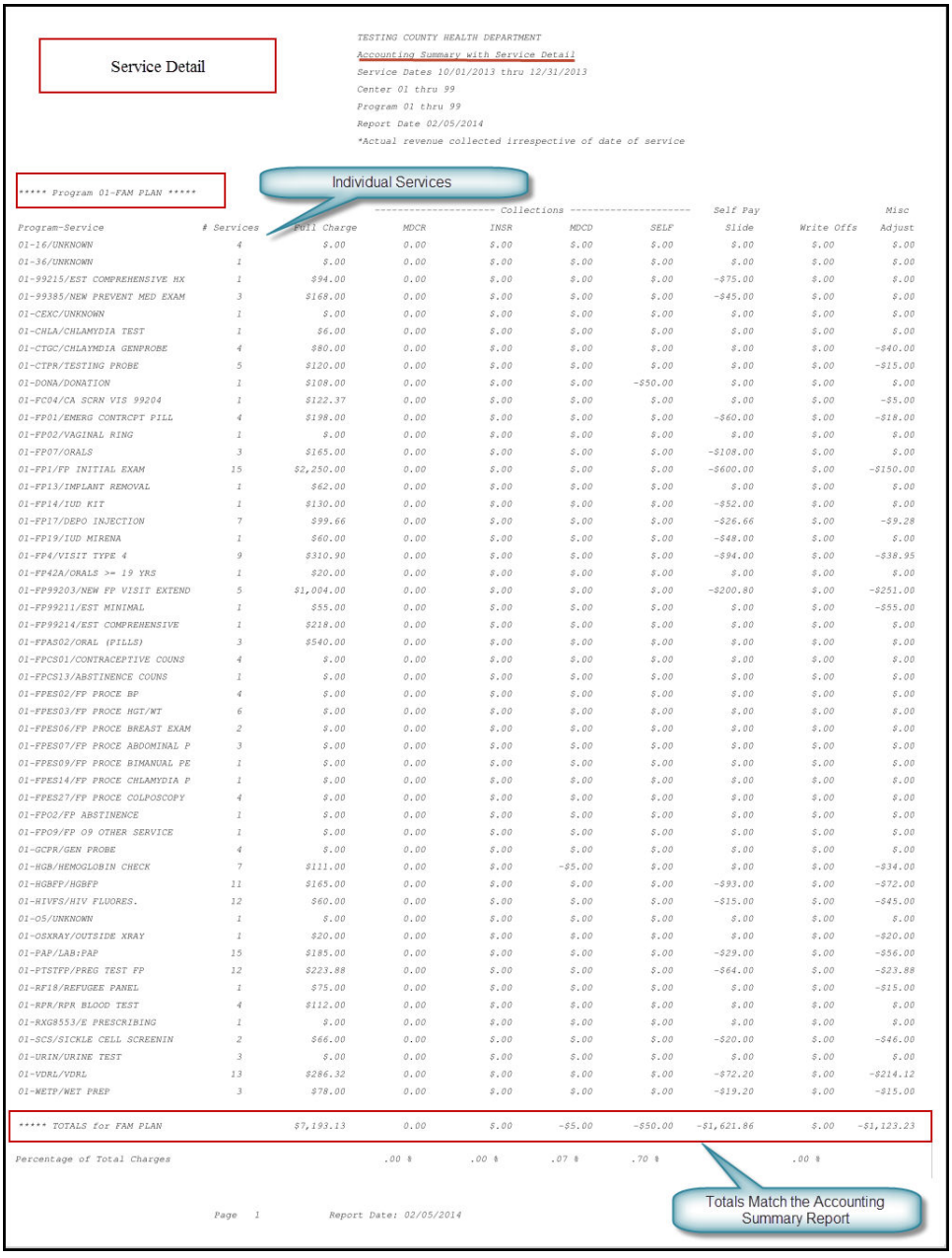
Create Incident

To have incident added to the menu. Indicate menu option to place report. Allow 7-10 working days to have change made to the menu.


ANYTEST COUNTY HEALTH DEPARTMENT
Possible Claim Write off Report
Centers 01 thru 99
Program 01 thru 99
Service Date 01/01/2013 thru 09/30/2013
ALL Payment Types
Payment Type 04
00002201 08/12/2013 MMR2 90707 Payment Type 04
Pay Date 08/12/2013 Code 723 Amt $60.50 Entered By: tracy
Pay Date 08/12/2013 Code 321 Amt $60.50 Entered By: tracy
Pay Date 08/12/2013 Code 399 Amt $121.00 Entered By: tracy
00002201 08/12/2013 IPV1 90713 Payment Type 04
Pay Date 08/12/2013 Code 723 Amt $8.00 Entered By: tracy
Pay Date 08/12/2013 Code 321 Amt $16.00 Entered By: tracy
723 = NC Only Write Off of Immunizations
321 = Insurance Credit Adjustment (-)
399 = Insurance Disallowed Amount
Type 04
$10.00 Entered By: tracy
$10.00 Entered By: tracy
00002345 07/08/2013 FP17 J1050 Payment Type 03
Pay Date 07/08/2013 Code 101 Amt $.23 Entered By: ranee
00002600 07/08/2013 MMR1 90707 Payment Type 02
Pay Date 07/08/2013 Code 100 Amt $63.35 Entered By: lynne

2. Addition to Accounting Summary report

Additional Service Detail available
Includes for a specific date range,
Charges for individual services per program
Total per program
Total for all programs
Optional Report
Select the Accounting Summary Report from a Billing menu option
Complete the parameters
To print the Service Detail enter "Y"
Default for Service Detail is "N"


Service Detail
TESTING COUNTY HEALTH DEPARTMENT
Accounting Summary with Service Detail
Service Dates 10/01/2013 thru 12/31/2013
Center 01 thru 99
Program 01 thru 99
Report Date 02/05/2014
*Actual revenue collected irrespective of date of service
***** Program 01-FAM PLAN *****
Individual Services
Totals Match the Accounting Summary Report

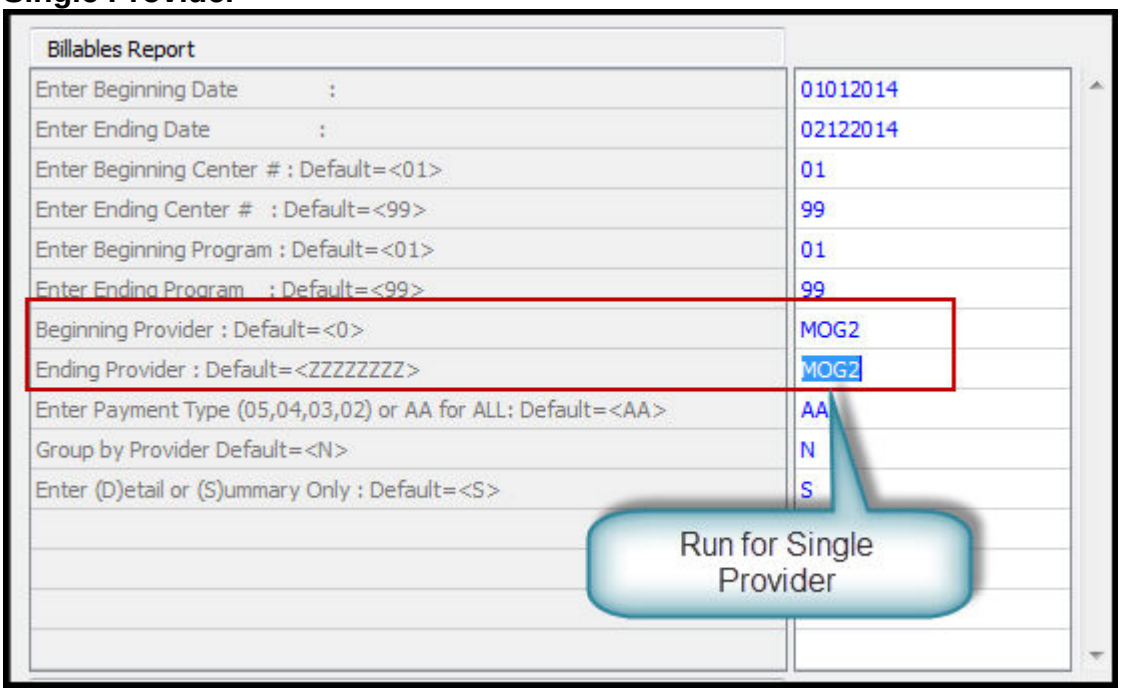
Program-Service	# Services	Full Charge	Collections MDCR	INSR	MDCD	SELF	Self Pay Slide	Write Offs	Misc Adjust
01-16/UNKNOWN	4	$.00	0.00	$.00	$.00	$.00	$.00	$.00	$.00
01-36/UNKNOWN	1	$.00	0.00	$.00	$.00	$.00	$.00	$.00	$.00
01-99215/EST COMPREHENSIVE HX	1	$94.00	0.00	$.00	$.00	$.00	-$75.00	$.00	$.00
01-99385/NEW PREVENT MED EXAM	3	$168.00	0.00	$.00	$.00	$.00	-$45.00	$.00	$.00
01-CEXC/UNKNOWN	1	$.00	0.00	$.00	$.00	$.00	$.00	$.00	$.00
01-CHLA/CHLAMYDIA TEST	1	$6.00	0.00	$.00	$.00	$.00	$.00	$.00	$.00
01-CTGC/CHLAYMDIA GENPROBE	4	$80.00	0.00	$.00	$.00	$.00	$.00	$.00	-$40.00
01-CTPR/TESTING PROBE	5	$120.00	0.00	$.00	$.00	$.00	$.00	$.00	-$15.00
01-DONA/DONATION	1	$108.00	0.00	$.00	$.00	-$50.00	$.00	$.00	$.00
01-FC04/CA SCRN VIS 99204	1	$122.37	0.00	$.00	$.00	$.00	$.00	$.00	-$5.00
01-FP01/EMERG CONTRCPT PILL	4	$198.00	0.00	$.00	$.00	$.00	-$60.00	$.00	-$18.00
01-FP02/VAGINAL RING	1	$.00	0.00	$.00	$.00	$.00	$.00	$.00	$.00
01-FP07/ORALS	3	$165.00	0.00	$.00	$.00	$.00	-$108.00	$.00	$.00
01-FP1/FP INITIAL EXAM	15	$2,250.00	0.00	$.00	$.00	$.00	-$600.00	$.00	-$150.00
01-FP13/IMPLANT REMOVAL	1	$62.00	0.00	$.00	$.00	$.00	$.00	$.00	$.00
01-FP14/IUD KIT	1	$130.00	0.00	$.00	$.00	$.00	-$52.00	$.00	$.00
01-FP17/DEPO INJECTION	7	$99.66	0.00	$.00	$.00	$.00	-$26.66	$.00	-$9.28
01-FP19/IUD MIRENA	1	$60.00	0.00	$.00	$.00	$.00	-$48.00	$.00	$.00
01-FP4/VISIT TYPE 4	9	$310.90	0.00	$.00	$.00	$.00	-$94.00	$.00	-$38.95
01-FP42A/ORALS >= 19 YRS	1	$20.00	0.00	$.00	$.00	$.00	$.00	$.00	$.00
01-FP99203/NEW FP VISIT EXTEND	5	$1,004.00	0.00	$.00	$.00	$.00	-$200.80	$.00	-$251.00
01-FP99211/EST MINIMAL	1	$55.00	0.00	$.00	$.00	$.00	$.00	$.00	-$55.00
01-FP99214/EST COMPREHENSIVE	1	$218.00	0.00	$.00	$.00	$.00	$.00	$.00	$.00
01-FPAS02/ORAL (PILLS)	3	$540.00	0.00	$.00	$.00	$.00	$.00	$.00	$.00
01-FPCS01/CONTRACEPTIVE COUNS	4	$.00	0.00	$.00	$.00	$.00	$.00	$.00	$.00
01-FPCS13/ABSTINENCE COUNS	1	$.00	0.00	$.00	$.00	$.00	$.00	$.00	$.00
01-FPES02/FP PROCE BP	4	$.00	0.00	$.00	$.00	$.00	$.00	$.00	$.00
01-FPES03/FP PROCE HGT/WT	6	$.00	0.00	$.00	$.00	$.00	$.00	$.00	$.00
01-FPES06/FP PROCE BREAST EXAM	2	$.00	0.00	$.00	$.00	$.00	$.00	$.00	$.00
01-FPES07/FP PROCE ABDOMINAL P	3	$.00	0.00	$.00	$.00	$.00	$.00	$.00	$.00
01-FPES09/FP PROCE BIMANUAL PE	1	$.00	0.00	$.00	$.00	$.00	$.00	$.00	$.00
01-FPES14/FP PROCE CHLAMYDIA P	1	$.00	0.00	$.00	$.00	$.00	$.00	$.00	$.00
01-FPES27/FP PROCE COLPOSCOPY	4	$.00	0.00	$.00	$.00	$.00	$.00	$.00	$.00
01-FPO2/FP ABSTINENCE	1	$.00	0.00	$.00	$.00	$.00	$.00	$.00	$.00
01-FPO9/FP O9 OTHER SERVICE	1	$.00	0.00	$.00	$.00	$.00	$.00	$.00	$.00
01-GCPR/GEN PROBE	4	$.00	0.00	$.00	$.00	$.00	$.00	$.00	$.00
01-HGB/HEMOGLOBIN CHECK	7	$111.00	0.00	$.00	-$5.00	$.00	$.00	$.00	-$34.00
01-HGBFP/HGBFP	11	$165.00	0.00	$.00	$.00	$.00	-$93.00	$.00	-$72.00
01-HIVFS/HIV FLUORES.	12	$60.00	0.00	$.00	$.00	$.00	-$15.00	$.00	-$45.00
01-O5/UNKNOWN	1	$.00	0.00	$.00	$.00	$.00	$.00	$.00	$.00
01-OSXRAY/OUTSIDE XRAY	1	$20.00	0.00	$.00	$.00	$.00	$.00	$.00	-$20.00
01-PAP/LAB:PAP	15	$185.00	0.00	$.00	$.00	$.00	-$29.00	$.00	-$56.00
01-PTSTFP/PREG TEST FP	12	$223.88	0.00	$.00	$.00	$.00	-$64.00	$.00	-$23.88
01-RF18/REFUGEE PANEL	1	$75.00	0.00	$.00	$.00	$.00	$.00	$.00	-$15.00
01-RPR/RPR BLOOD TEST	4	$112.00	0.00	$.00	$.00	$.00	$.00	$.00	$.00
01-RXG8553/E PRESCRIBING	1	$.00	0.00	$.00	$.00	$.00	$.00	$.00	$.00
01-SCS/SICKLE CELL SCREENIN	2	$66.00	0.00	$.00	$.00	$.00	-$20.00	$.00	-$46.00
01-URIN/URINE TEST	3	$.00	0.00	$.00	$.00	$.00	$.00	$.00	$.00
01-VDRL/VDRL	13	$286.32	0.00	$.00	$.00	$.00	-$72.20	$.00	-$214.12
01-WETP/WET PREP	3	$78.00	0.00	$.00	$.00	$.00	-$19.20	$.00	-$15.00
***** TOTALS for FAM PLAN		$7,193.13	0.00	$.00	-$5.00	-$50.00	-$1,621.86	$.00	-$1,123.23
Percentage of Total Charges			.00 %	.00 %	.07 %	.70 %		.00 %	

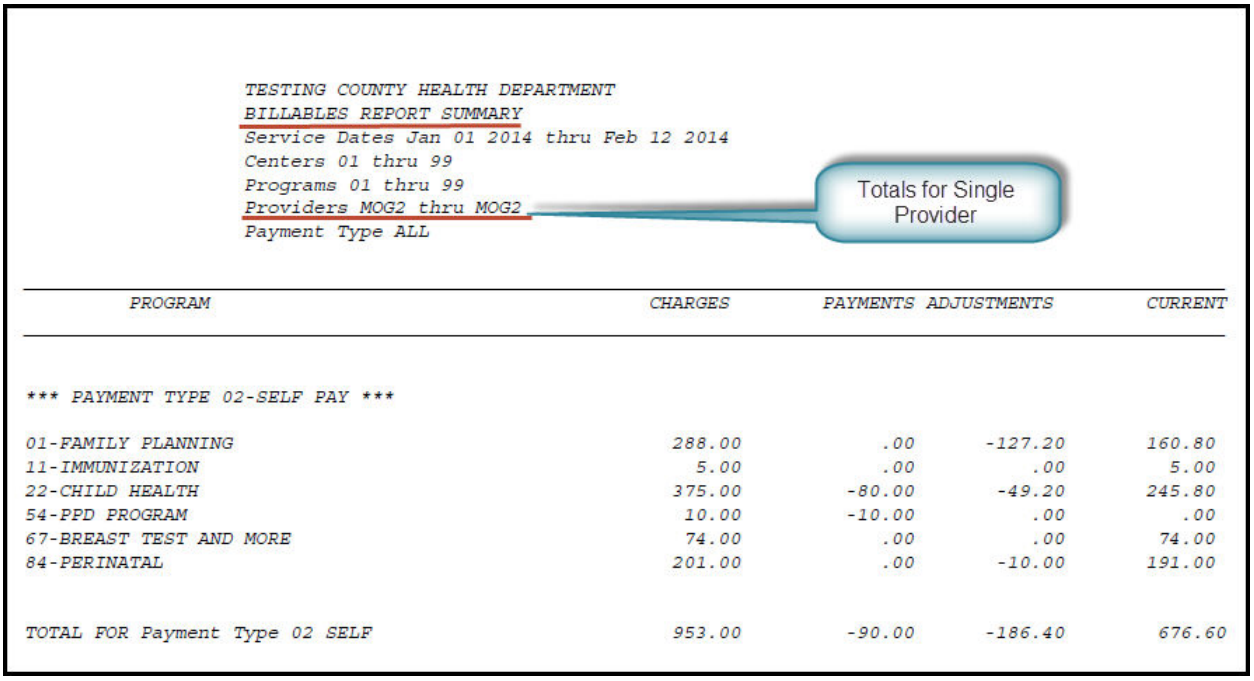
Page 1 Report Date: 02/05/2014

3. Billables Report

- Added ability to sort by provider
- Run report for a single provider or all
- Run report by provider for a specific program
- To generate report for a single provider
- Enter the single provider code in the Beginning and Ending Provider parameters
- To group report by multiple providers
- Enter the Beginning and Ending Provider parameters. Allow to default for all providers
- Group by Provider MUST BE "Y"

Single Provider



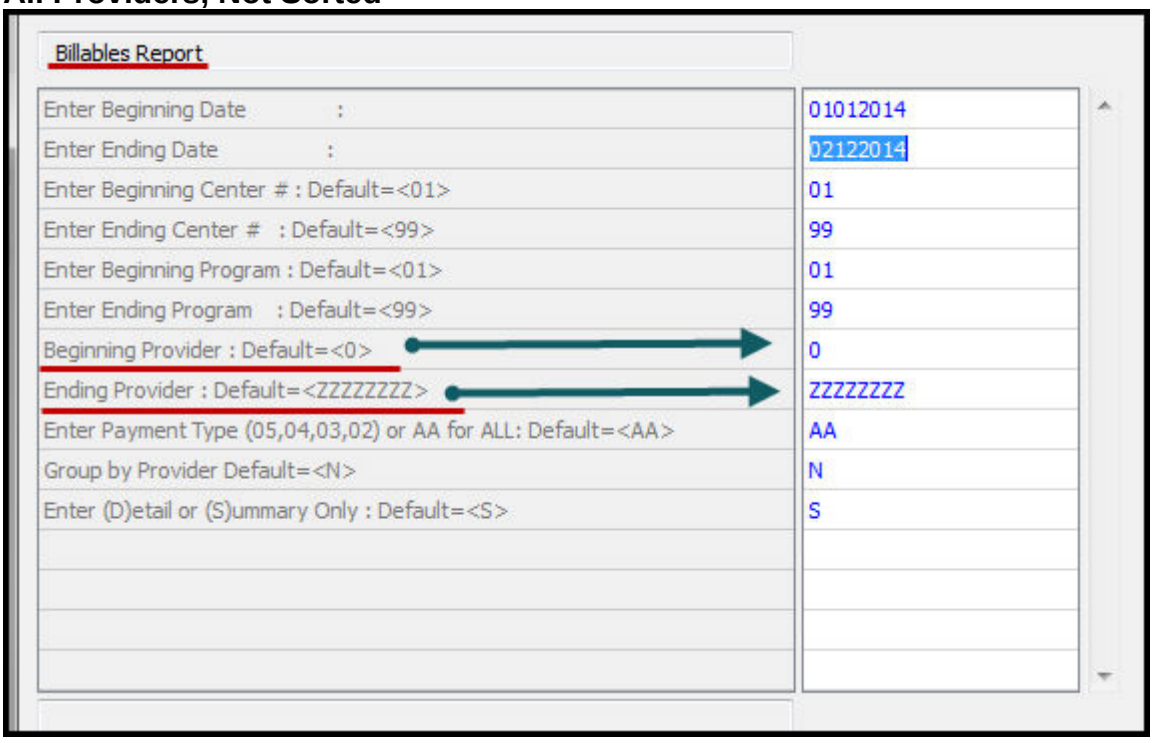


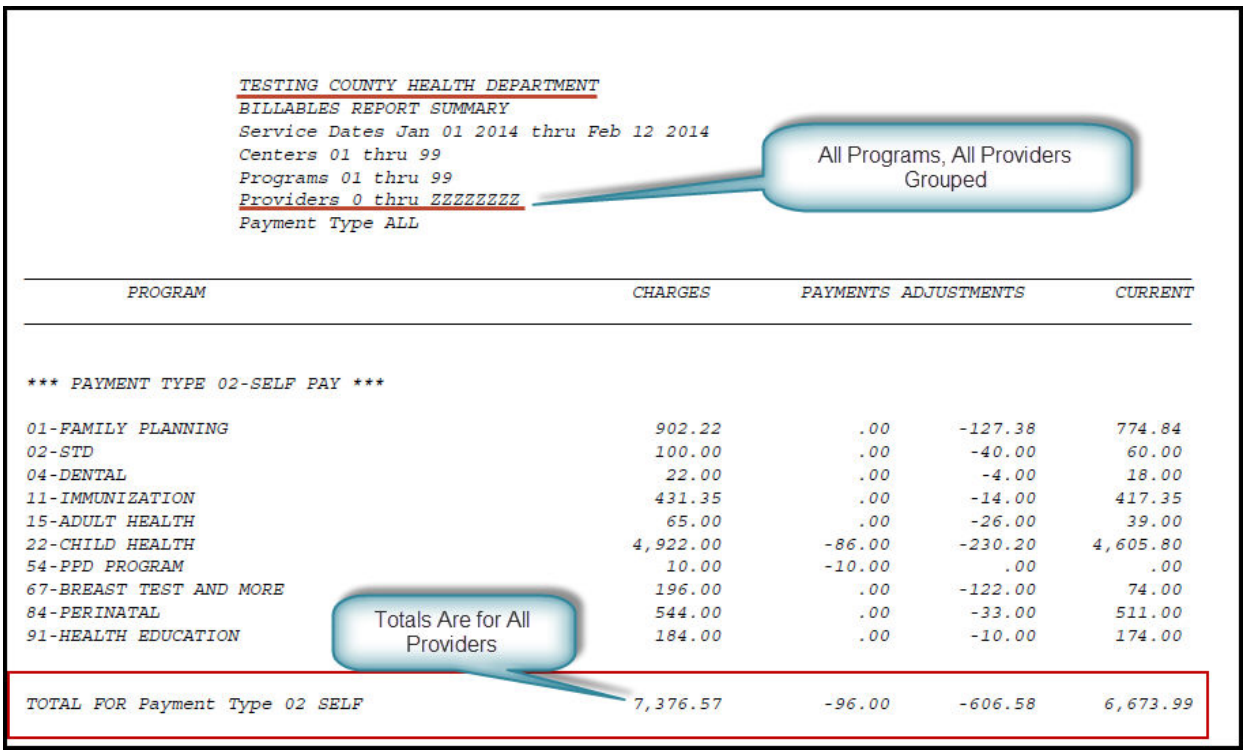
TESTING COUNTY HEALTH DEPARTMENT
BILLABLES REPORT SUMMARY
Service Dates Jan 01 2014 thru Feb 12 2014
Centers 01 thru 99
Programs 01 thru 99
Providers MOG2 thru MOG2
Payment Type ALL

Totals for Single Provider

PROGRAM	CHARGES	PAYMENTS	ADJUSTMENTS	CURRENT
*** PAYMENT TYPE 02-SELF PAY ***				
01-FAMILY PLANNING	288.00	.00	-127.20	160.80
11-IMMUNIZATION	5.00	.00	.00	5.00
22-CHILD HEALTH	375.00	-80.00	-49.20	245.80
54-PPD PROGRAM	10.00	-10.00	.00	.00
67-BREAST TEST AND MORE	74.00	.00	.00	74.00
84-PERINATAL	201.00	.00	-10.00	191.00
TOTAL FOR Payment Type 02 SELF	953.00	-90.00	-186.40	676.60

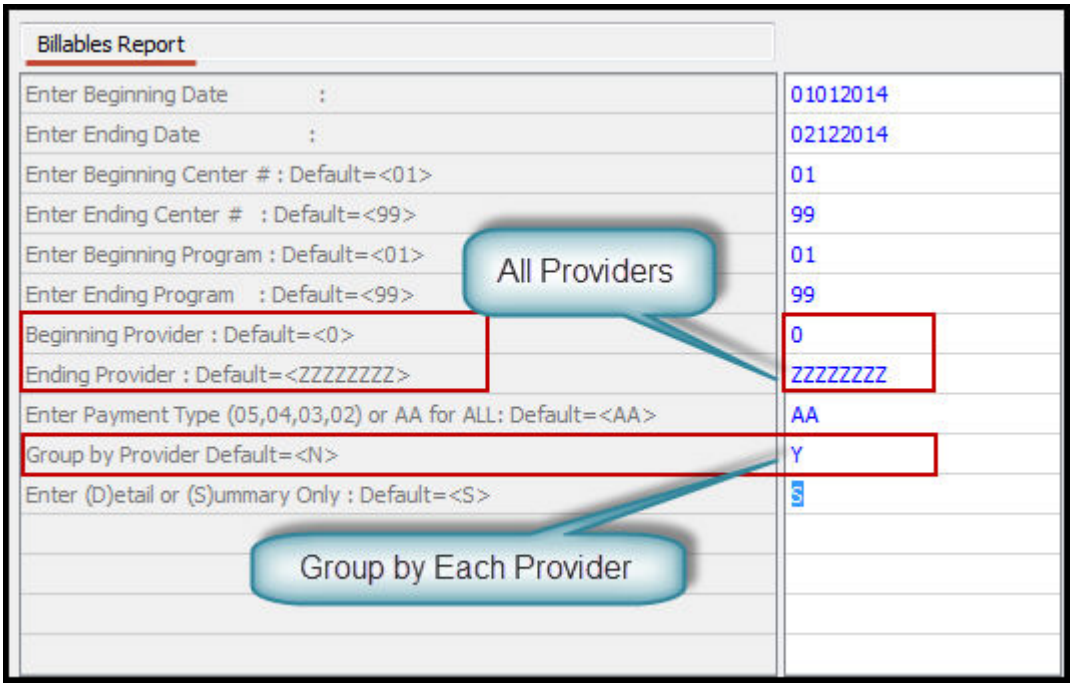
All Providers, Not Sorted

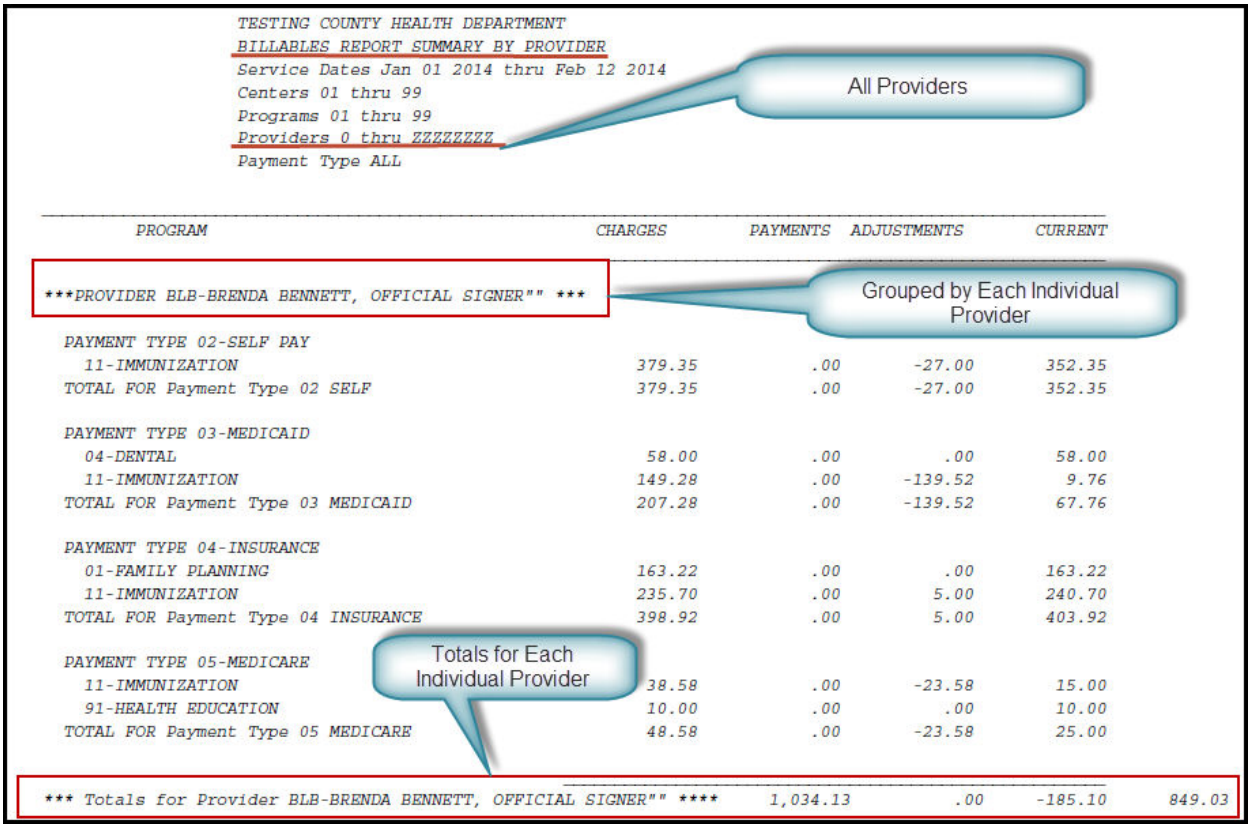




TESTING COUNTY HEALTH DEPARTMENT
BILLABLES REPORT SUMMARY
Service Dates Jan 01 2014 thru Feb 12 2014
Centers 01 thru 99
Programs 01 thru 99
Providers 0 thru ZZZZZZZZ
Payment Type ALL

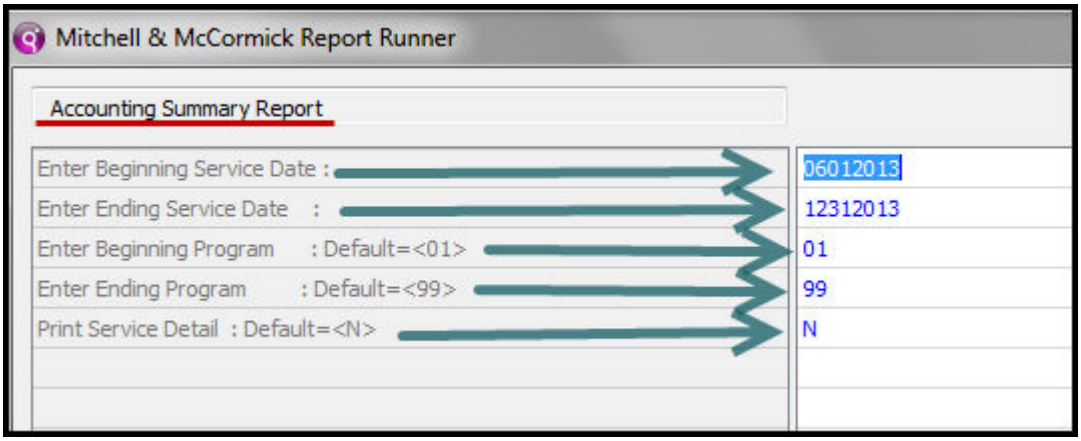
PROGRAM	CHARGES	PAYMENTS	ADJUSTMENTS	CURRENT
*** PAYMENT TYPE 02-SELF PAY ***				
01-FAMILY PLANNING	902.22	.00	-127.38	774.84
02-STD	100.00	.00	-40.00	60.00
04-DENTAL	22.00	.00	-4.00	18.00
11-IMMUNIZATION	431.35	.00	-14.00	417.35
15-ADULT HEALTH	65.00	.00	-26.00	39.00
22-CHILD HEALTH	4,922.00	-86.00	-230.20	4,605.80
54-PPD PROGRAM	10.00	-10.00	.00	.00
67-BREAST TEST AND MORE	196.00	.00	-122.00	74.00
84-PERINATAL	544.00	.00	-33.00	511.00
91-HEALTH EDUCATION	184.00	.00	-10.00	174.00
TOTAL FOR Payment Type 02 SELF	7,376.57	-96.00	-606.58	6,673.99

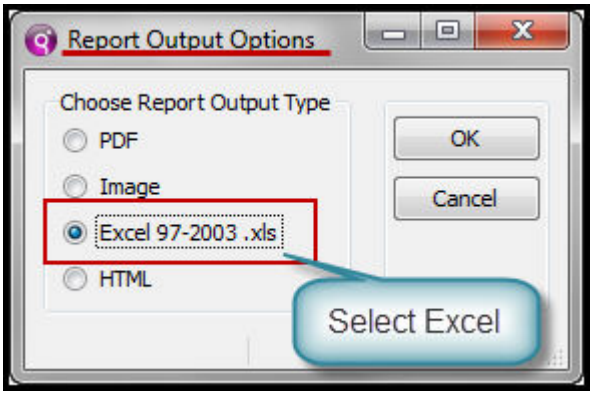


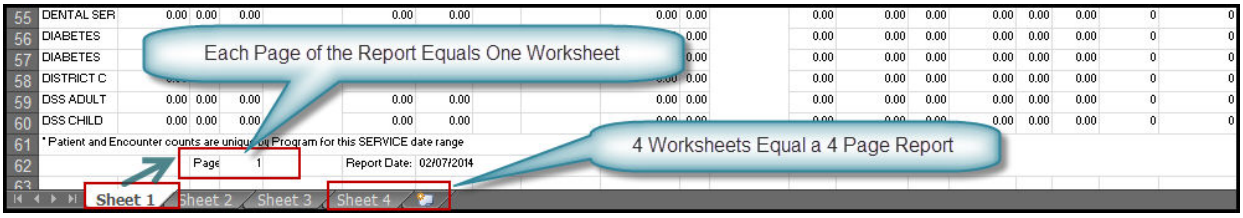

TESTING COUNTY HEALTH DEPARTMENT
BILLABLES REPORT SUMMARY BY PROVIDER
Service Dates Jan 01 2014 thru Feb 12 2014
Centers 01 thru 99
Programs 01 thru 99
Providers 0 thru ZZZZZZZZ
Payment Type ALL
All Providers
PROGRAM CHARGES PAYMENTS ADJUSTMENTS CURRENT
***PROVIDER BLB-BRENDA BENNETT, OFFICIAL SIGNER"" ***
Grouped by Each Individual Provider
PAYMENT TYPE 02-SELF PAY
11-IMMUNIZATION 379.35 .00 -27.00 352.35
TOTAL FOR Payment Type 02 SELF 379.35 .00 -27.00 352.35
PAYMENT TYPE 03-MEDICAID
04-DENTAL 58.00 .00 .00 58.00
11-IMMUNIZATION 149.28 .00 -139.52 9.76
TOTAL FOR Payment Type 03 MEDICAID 207.28 .00 -139.52 67.76
PAYMENT TYPE 04-INSURANCE
01-FAMILY PLANNING 163.22 .00 .00 163.22
11-IMMUNIZATION 235.70 .00 5.00 240.70
TOTAL FOR Payment Type 04 INSURANCE 398.92 .00 5.00 403.92
PAYMENT TYPE 05-MEDICARE
11-IMMUNIZATION 38.58 .00 -23.58 15.00
91-HEALTH EDUCATION 10.00 .00 .00 10.00
TOTAL FOR Payment Type 05 MEDICARE 48.58 .00 -23.58 25.00
Totals for Each Individual Provider
*** Totals for Provider BLB-BRENDA BENNETT, OFFICIAL SIGNER"" **** 1,034.13 .00 -185.10 849.03

Billing reports optional output

1. Billing reports can now output to Excel
2. Must have Excel 97-2003.xls on the local PC
3. Each page of the report becomes a sheet in the spread sheet
4. M&M does not support Excel or assist in data manipulation
5. Reports currently available to export to Excell
6. Accounting Summary
7. Claim Cycle
8. Billing Activity
9. Payor Mix
10. Payor Mix Under 5
11. Payor Mix By Age
12. Access
13. Select the report from the appropriate menu option
14. Enter the report parameters
15. New screen called: Report Output Options displays
16. Click Excel and OK
17. Excel opens and report inserts

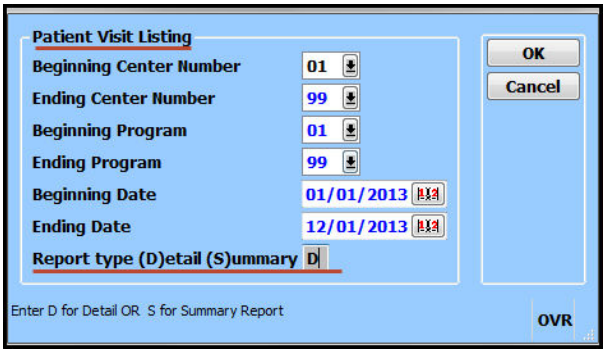

Mitchell & McCormick Report Runner
Accounting Summary Report
Enter Beginning Service Date :
Enter Ending Service Date :
Enter Beginning Program : Default=<01>
Enter Ending Program : Default=<99>
Print Service Detail : Default=<N>
06012013
12312013
01
99
N

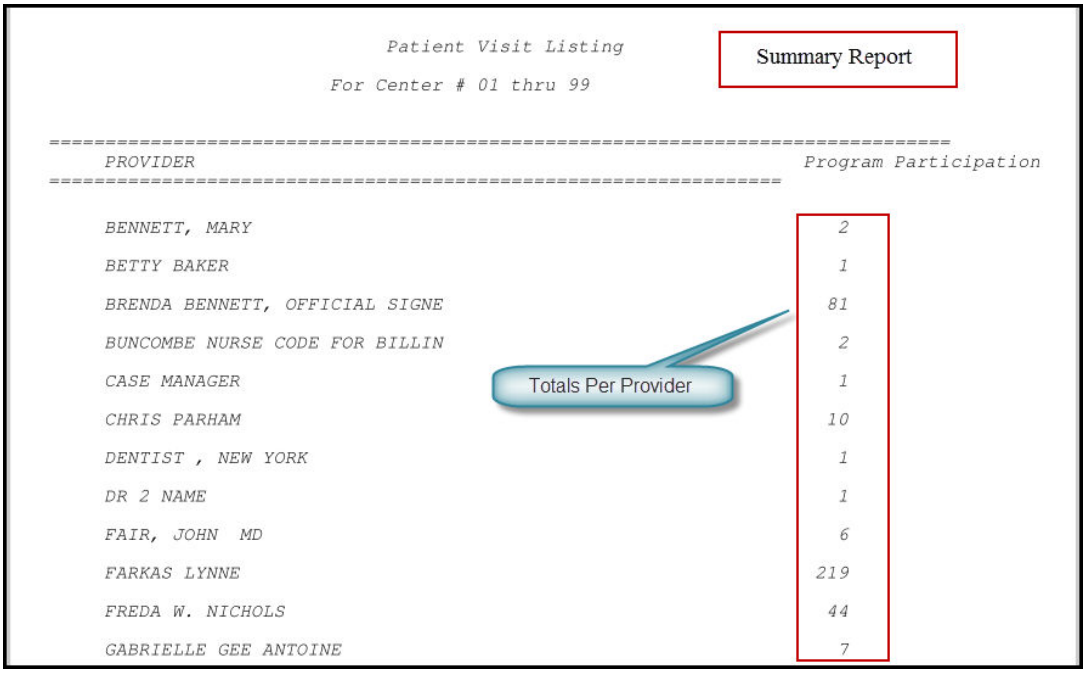

Report Output Options
Choose Report Output Type
PDF
Image
Excel 97-2003 .xls
HTML
OK
Cancel
Select Excel


Each Page of the Report Equals One Worksheet
4 Worksheets Equal a 4 Page Report
Sheet 1
Sheet 2
Sheet 3
Sheet 4

Reports

1. Visit List by Provider with OV
    a. Modification to Patient Visit List
    b. Prints the office visit code for the encounter
    c. Run Patient Visit List
    d. Run by Summary: Prints totals by provider
    e. Run by Detail: Prints a listing of patient's by provider and the summary totals





Patient Visit Listing

For Center # 01 thru 99

From : 01/01/2013 to 12/02/2013

Detail Listing for Provider

Includes Office Visit Code

Provider: FARKAS LYNNE

Pt.#	Last name	First name	M.I.	Vis. Date	Race	Sex	D.O.B.	Office Visit
412323	ACKERMAN	JAMIE		07/05/2013	W	M	01/13/1990	
394101	ADDICKS	SARAH	A	09/16/2013	W	F	03/30/1992	
394101	ADDICKS	SARAH	A	09/16/2013	W	F	03/30/1992	99203
8200	AKIRYEMI	RALPH		10/16/2013	B	M	08/19/1987	
8801	ALEXANDER	STACEY		01/08/2013	B	F	01/13/1988	99203
8005	ANDREWS	EMILY	B	10/04/2013	W	F	07/06/1987	99211
9959	AVERY	KIMBERLY	A	11/27/2013	W	F	08/10/1955	04
433604	BARBER	ANITA		07/02/2013	B	F	05/13/1988	
17672	BARBER	JASMINE		01/24/2013	B	M	08/14/1991	
1567	BLAND	KENNETH		11/18/2013	N	M	05/25/1981	
4000	BOATRIGHT	RYAN		05/02/2013	W	F	04/24/1984	
4000	BOATRIGHT	RYAN		10/01/2013	W	F	04/24/1984	99203
400224	BORSOS	BETHANIE		09/19/2013	W	F	10/15/1987	99203
6002	BRANNOCK	KRISTINE	N	08/28/2013	W	F	01/29/1986	
6708	BROWN	CHRISTOPHER		08/15/2013	W	M	08/18/2001	
6003	BUCKEL	ASHLEY		08/28/2013	W	F	01/29/1986	
176771	BUNCKER	JOSEPHINE		11/26/2013	W	F	05/04/1954	04
7659	BURKS	ANGELINA		11/26/2013	B	F	04/05/1952	04
8004	BUSTER	BRINNY		10/04/2013	W	F	07/04/1987	99203
17616	CALDWELL	MARIAH		01/24/2013	W	F	08/07/1991	
3222	CAMP	WENDY	M	07/17/2013	W	F	07/16/1983	
7000	CASEY	BRENDA	R	08/29/2013	W	F	10/22/1990	99211

Buncombe County, NC Only: Lab Only will display in place of the office visit code when the patient has labs done without an open encounter.

Patient Visit Listing

For Center # 01 thru 95

From : 12/03/2013 to 12/03/2013

Buncombe County Only

Provider: GRISCOM, MARGARET

Pt.#	Last name	First name	M.I.	Vis. Date	Race	Sex	D.O.B.	Office Visit
380214	NGECU	KAMUYU		12/03/2013	B	F	01/04/1990	LAB ONLY

2. New Appointment Report
    1. Patient's Medicaid number
        1. Allows for number to be verified before patient visit
        2. Allows for Mzoom for patient to be used if needed

2. Select Appointment reports from the menu options
    1. Select Print Appt List by Primary Payer
    2. Enter the parameters

Authorization Form

1. Name of the Health Department added to the form
2. Access the Authorization Screen
    1. Patient/More/authoriZe
    2. Patient Summary/Authorization
3. Add
    1. Each record request requires a NEW authorization
    2. Complete the required fields

4. Pap Log Report

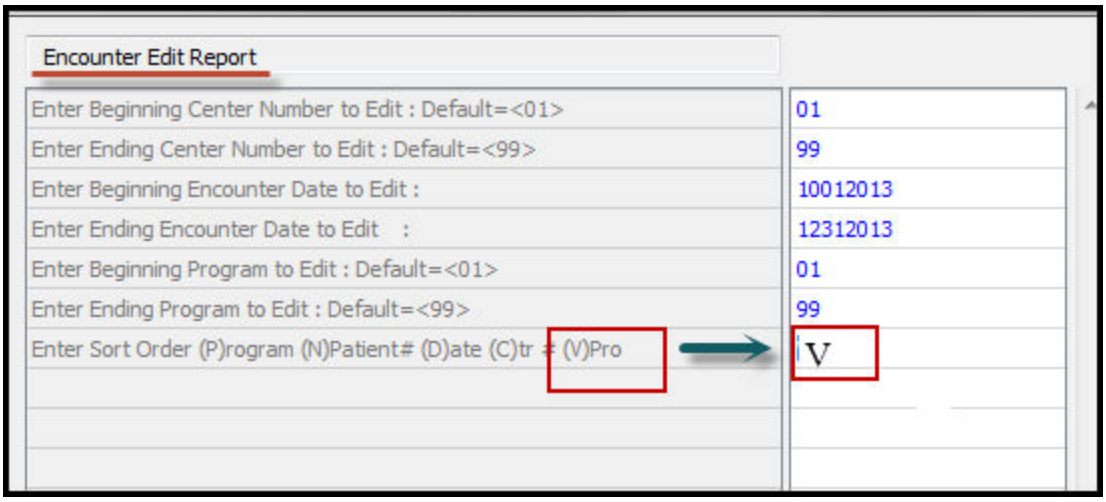
    1. Indicator that patient has Medicaid at the time the Pap was ordered
    2. Access the Pap Log from the menu
    3. Enter the parameters
    4. The report runs with Medicaid indicated

5. Outside Lab Log

    1. Update print out
    2. Now prints:
        1. Date Result Received
        2. Result Date
    3. Run the report from the menu option
        1. Enter the parameters
        2. OK to print the report

Encounter Edit Report

1. Additional sort function added
    1. Able to sort by provider
    2. Allows report to sort as before if needed
2. Access Encounter Edit Report from the Fees menu
    1. Enter parameters
    2. Sort Order now includes "V" for providers
    3. Report generates by provider.


Encounter Edit Report
Enter Beginning Center Number to Edit : Default=<01>
01
Enter Ending Center Number to Edit : Default=<99>
99
Enter Beginning Encounter Date to Edit :
10012013
Enter Ending Encounter Date to Edit :
12312013
Enter Beginning Program to Edit : Default=<01>
01
Enter Ending Program to Edit : Default=<99>
99
Enter Sort Order (P)rogram (N)Patient# (D)ate (C)tr # (V)Pro
V

TESTING COUNTY HEALTH DEPARTMENT
Encounter Edit Report
Service Dates Oct 01, 2013 thru Dec 31, 2013
Center : 01 thru 99
Program: 01 thru 99
Sorted by Provider in Error

Patient #	Enc Number / Pat Name	Ctr	Servdate	Prog	Error
Provider 929-HOLLAND MARY RN					
380246	11698666 CHALKIAS, ANTHONY	01	12/31/2013	IM	No Diagnosis Specified
380246	11698570 CHALKIAS, ANTHONY	01	12/31/2013	IM	Billing record does not exist
380246	11698570 CHALKIAS, ANTHONY	01	12/31/2013	IM	No Diagnosis Specified
380246	11698686 CHALKIAS, ANTHONY	01	12/31/2013	IM	No Diagnosis Specified
380246	11698699 CHALKIAS, ANTHONY	01	12/31/2013	IM	Billing record does not exist
380246	11698666 CHALKIAS, ANTHONY	01	12/31/2013	IM	Billing record does not exist
380246	11698699 CHALKIAS, ANTHONY	01	12/31/2013	IM	No Diagnosis Specified
380246	11698686 CHALKIAS, ANTHONY	01	12/31/2013	IM	Billing record does not exist
********** Total for Provider 929 8 **********					
Provider AQJ-JOSEPH ALLAN, MD					
380246	11698440 CHALKIAS, ANTHONY	01	12/31/2013	IM	Billing record does not exist
380246	11698486 CHALKIAS, ANTHONY	01	12/31/2013	IM	No Diagnosis Specified
380246	11698486 CHALKIAS, ANTHONY	01	12/31/2013	IM	Billing record does not exist
380246	11698491 CHALKIAS, ANTHONY	01	12/31/2013	IM	Billing record does not exist
380246	11698491 CHALKIAS, ANTHONY	01	12/31/2013	IM	No Diagnosis Specified
380246	11698440 CHALKIAS, ANTHONY	01	12/31/2013	IM	No Diagnosis Specified
380246	11698469 CHALKIAS, ANTHONY	01	12/31/2013	IM	Billing record does not exist
380246	11698459 CHALKIAS, ANTHONY	01	12/31/2013	IM	No Diagnosis Specified
380246	11698487 CHALKIAS, ANTHONY	01	12/31/2013	IM	No Diagnosis Specified
380246	11698438 CHALKIAS, ANTHONY	01	12/31/2013	IM	Billing record does not exist
380246	11698459 CHALKIAS, ANTHONY	01	12/31/2013	IM	Billing record does not exist
380246	11698487 CHALKIAS, ANTHONY	01	12/31/2013	IM	Billing record does not exist
380246	11698469 CHALKIAS, ANTHONY	01	12/31/2013	IM	No Diagnosis Specified
380246	11698465 CHALKIAS, ANTHONY	01	12/31/2013	IM	Billing record does not exist
380246	11698438 CHALKIAS, ANTHONY	01	12/31/2013	IM	No Diagnosis Specified
380246	11698465 CHALKIAS, ANTHONY	01	12/31/2013	IM	No Diagnosis Specified
********** Total for Provider AQJ 16 **********					

9. Overdue Referrals
    1. New option added to Referral Report
        1. Shows all referrals due before a specific date
        2. Includes
            1. Patient number
            2. Patient name
            3. Referral date
            4. Referral Source
            5. Staff person responsible
            6. Referred By
                1. If a program then the program code
                2. If from outside, then the Facilities code for the organization
            7. Referred to
                1. Program code
                2. Facilities code
            8. Due Date
        3. Run for:
            1. Inside referrals
            2. Outside referrals
            3. Both in and out
    2. Access from:
        1. Referral Screen
        2. Reports

10. School Vision and Hearing Consolidated Report (For anyone using the School Based Vision and Hearing Module)

    1. Allows users to run a concise report as opposed to the "long" report
    2. Limit data to the following:
        1. Patient name
        2. Patient date of birth
        3. Grade
        4. Initial screening date and result
        5. Rescreen date and result
    3. Access the report
        1. Enter the parameters
        2. New prompt to print the Consolidated Format

11. Unsigned Encounters

    1. Lists encounters that have not been signed
        1. Patient number
        2. Date of service
        3. Program
        4. Center Number

5. Who created the encounter
6. Who updated the encounter

2. Run by program or for all programs

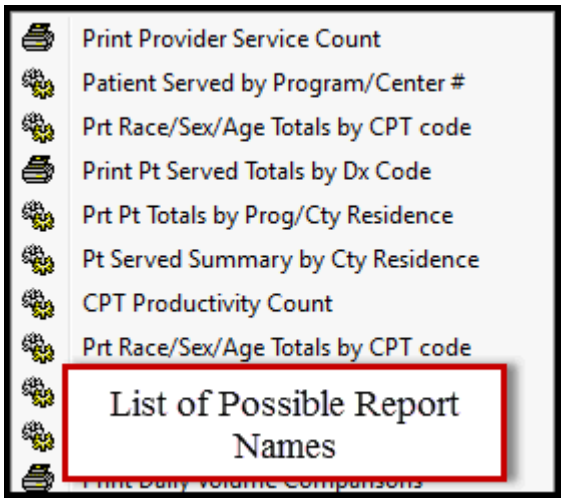
12. Encounter by Program

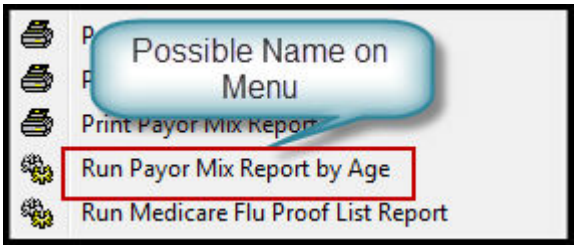
1. Sort by Program
2. Sort by Center
3. Runs from the same menu option

13. Productivity Reporting

1. Usually found under the Manage Reports
2. Group of several reports
    1. Patient served reports
    2. Payer Mix by Age reports
3. Now age grouping may be changed for these reports. A default age range is loaded with 11.3 release. System administrators may set up others that can be used by programs. If more than 1 age range has been set up, then it will ask the user which age range to use for the report.

To have age grouping changed for any other report. Enter the report name. Changes to reports will be not be guaranteed to be completed prior to the next release


Print Provider Service Count
Patient Served by Program/Center #
Prt Race/Sex/Age Totals by CPT code
Print Pt Served Totals by Dx Code
Prt Pt Totals by Prog/Cty Residence
Pt Served Summary by Cty Residence
CPT Productivity Count
Prt Race/Sex/Age Totals by CPT code
List of Possible Report Names

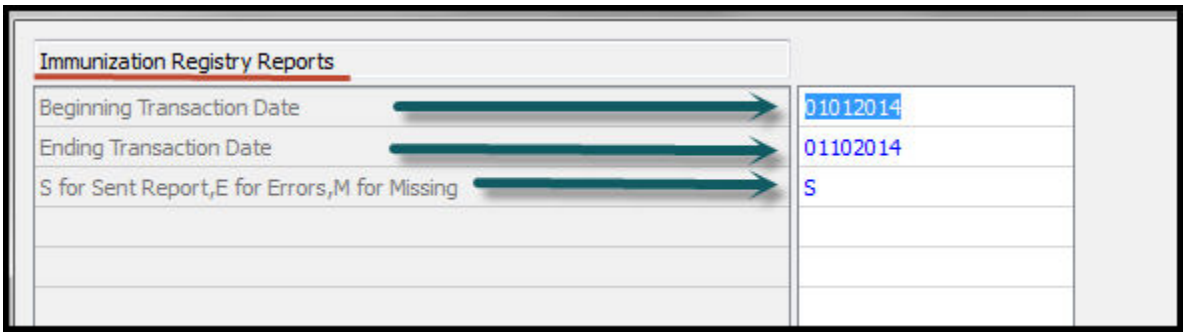


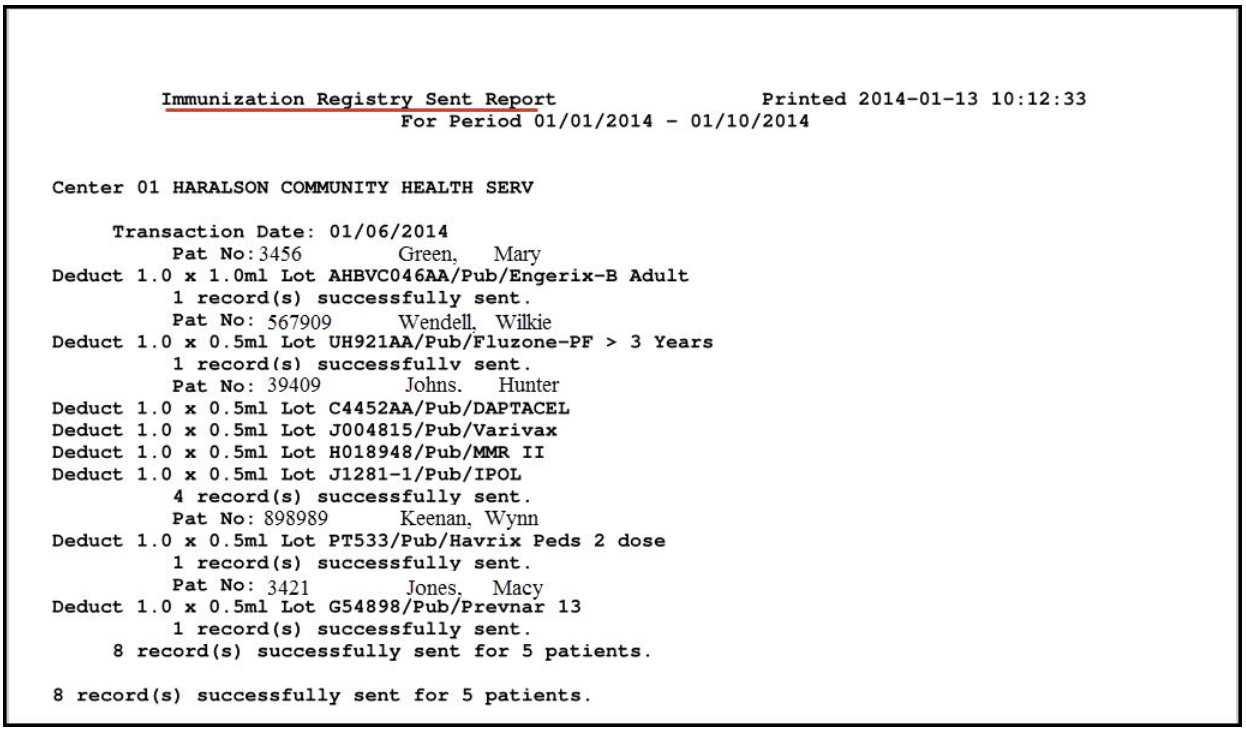
14. Lead Reports

1. Lead reports will print "No Data" messages when no items found that meet the report criteria.

Georgia Reports

1. GRITS Real Time Interface Error Reports
    1. Added to Immun Reports/RT IMM Reg Reports
    2. Enter the parameters for the report
        1. Each Report runs individually
        2. S: Immunizations Sent
        3. E: Errors
        4. M: Immunizations Missing



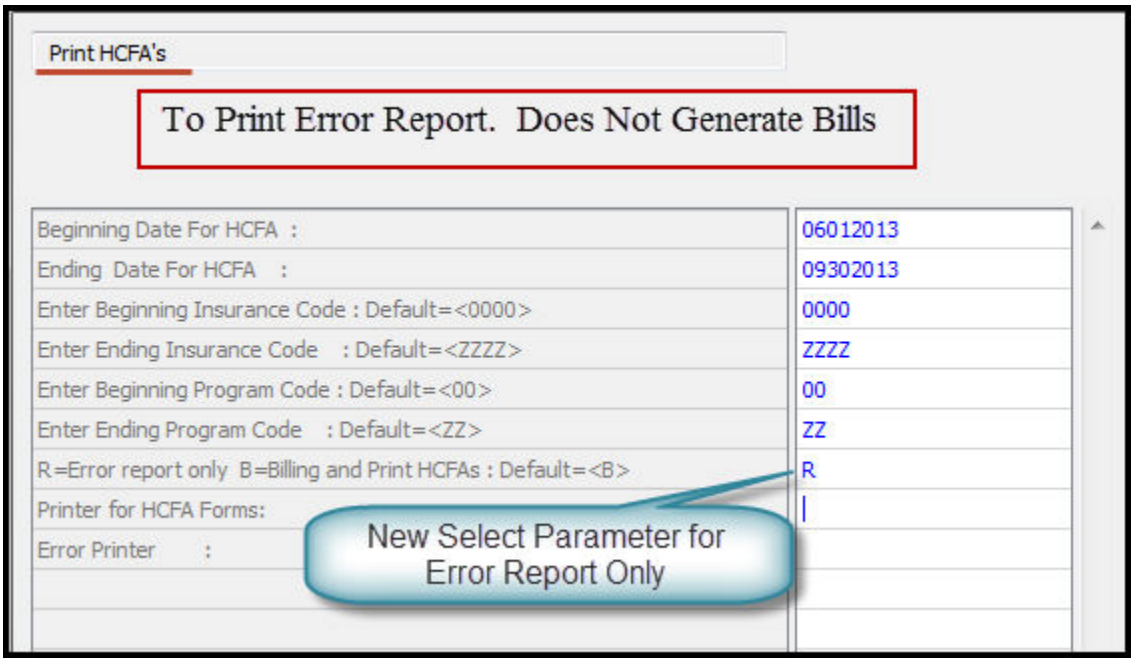


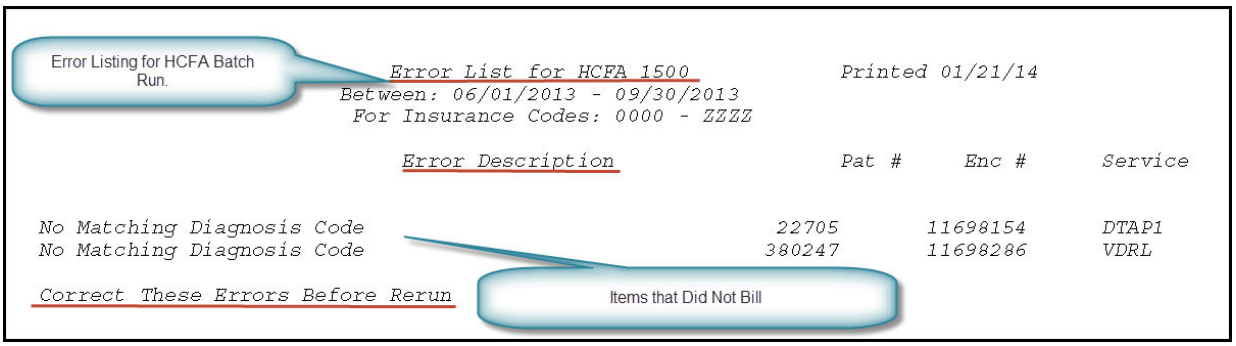
```
          Immunization Registry Sent Report                Printed 2014-01-13 10:12:33
                          For Period 01/01/2014 - 01/10/2014


Center 01 HARALSON COMMUNITY HEALTH SERV

     Transaction Date: 01/06/2014
          Pat No: 3456          Green,    Mary
Deduct 1.0 x 1.0ml Lot AHBVC046AA/Pub/Engerix-B Adult
          1 record(s) successfully sent.
          Pat No: 567909        Wendell,  Wilkie
Deduct 1.0 x 0.5ml Lot UH921AA/Pub/Fluzone-PF > 3 Years
          1 record(s) successfully sent.
          Pat No: 39409         Johns.    Hunter
Deduct 1.0 x 0.5ml Lot C4452AA/Pub/DAPTACEL
Deduct 1.0 x 0.5ml Lot J004815/Pub/Varivax
Deduct 1.0 x 0.5ml Lot H018948/Pub/MMR II
Deduct 1.0 x 0.5ml Lot J1281-1/Pub/IPOL
          4 record(s) successfully sent.
          Pat No: 898989        Keenan,   Wynn
Deduct 1.0 x 0.5ml Lot PT533/Pub/Havrix Peds 2 dose
          1 record(s) successfully sent.
          Pat No: 3421          Jones,    Macy
Deduct 1.0 x 0.5ml Lot G54898/Pub/Prevnar 13
          1 record(s) successfully sent.
     8 record(s) successfully sent for 5 patients.

8 record(s) successfully sent for 5 patients.
```

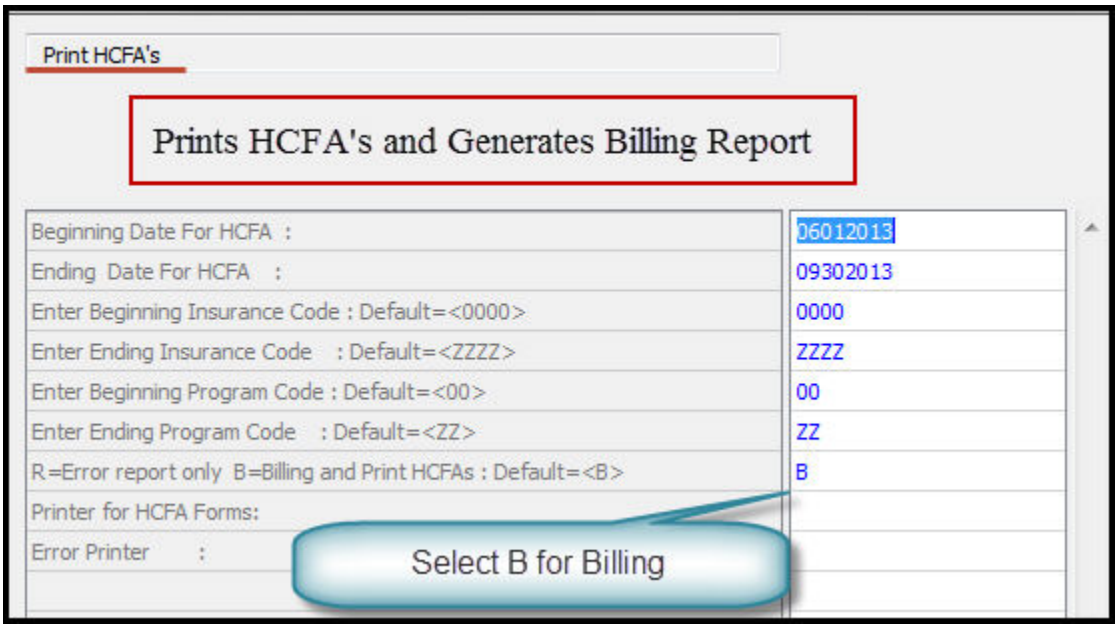
2. HCFA Batch Error Report

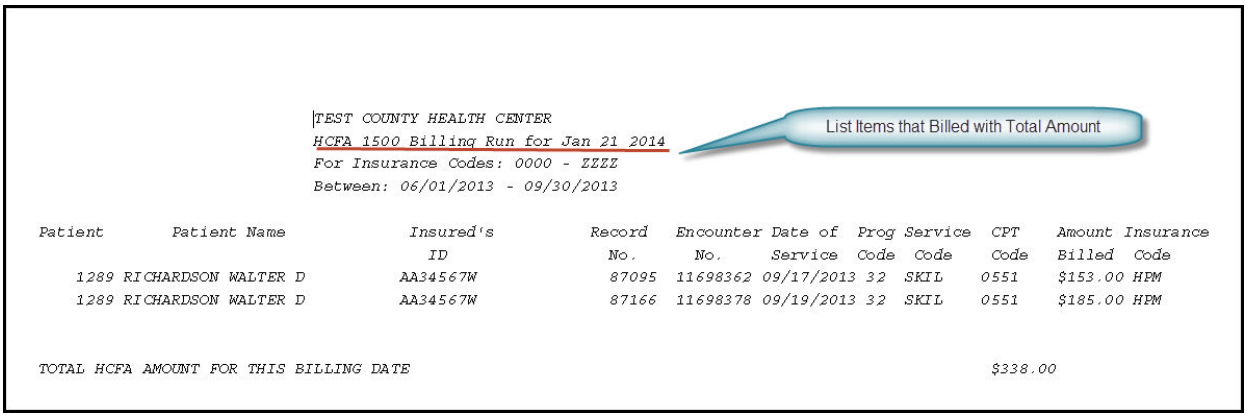
1. Added the ability to select just the error Report (R) or the Billing and Error report (B)
2. Option allows to run error report prior to running the batch
    1. No insert into the billing records
    2. Error Report only prints
3. Select Billing
    1. HCHA's print
    2. Listing of what was billed prints.

4. No change to process for billing individual HCFA's from the billing screen.








TEST COUNTY HEALTH CENTER
HCFA 1500 Billing Run for Jan 21 2014
For Insurance Codes: 0000 - ZZZZ
Between: 06/01/2013 - 09/30/2013
List Items that Billed with Total Amount
Patient Patient Name Insured's ID Record No. Encounter No. Date of Service Prog Code Service Code CPT Code Amount Billed Insurance Code
1289 RICHARDSON WALTER D AA34567W 87095 11698362 09/17/2013 32 SKIL 0551 $153.00 HPM
1289 RICHARDSON WALTER D AA34567W 87166 11698378 09/19/2013 32 SKIL 0551 $185.00 HPM
TOTAL HCFA AMOUNT FOR THIS BILLING DATE $338.00

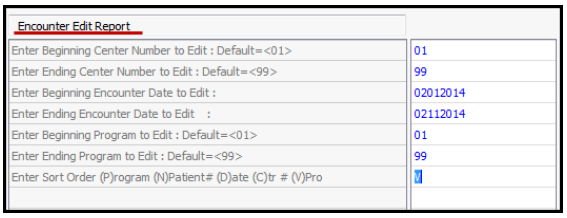
3. CMS Report
    1. New/Reinstated Client Report
        1. List new patients and patients that have been reinstated during a specific time frame
        2. Added to Management Reports 2
            1. Select New/Reinstated Client Report
            2. Enter the beginning and ending date for the report
            3. Report list patients newly enrolled or reinstated during the selected time frame

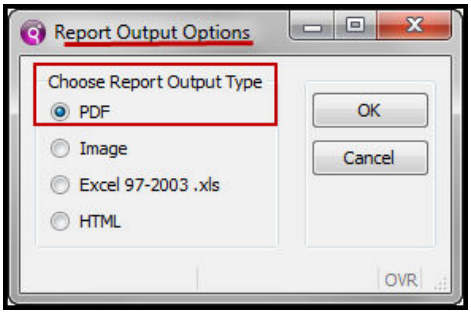
4. Billables
    1. Added functionality to report Medicaid information for Georgia
    2. Reports:
        1. Charges
        2. Amounts paid
        3. Current amounts due
        4. Reports by payment type
    3. Sort by
        1. Date range
        2. Programs
        3. Center
        4. Payment Type
            1. Run for all payment types or
            2. Can specify single payment type
        5. Summary or Detail report option
    4. Totals for each payment type
    5. Report Payments for services within the date range specified
    6. See Output Options under Reports

See Billing Reports for additional changes

For **Ware District Only**

1. Encounter Edit Report and FP Edit Report exception
    1. Report will not include items where the Provider is "S" (Schedule)
    2. Access the reports from the appropriate menus
    3. Enter the parameters
    4. Select the Output Option


Encounter Edit Report
Enter Beginning Center Number to Edit : Default=<01>
01
Enter Ending Center Number to Edit : Default=<99>
99
Enter Beginning Encounter Date to Edit :
02012014
Enter Ending Encounter Date to Edit :
02112014
Enter Beginning Program to Edit : Default=<01>
01
Enter Ending Program to Edit : Default=<99>
99
Enter Sort Order (P)rogram (N)Patient# (D)ate (C)tr # (V)Pro
V

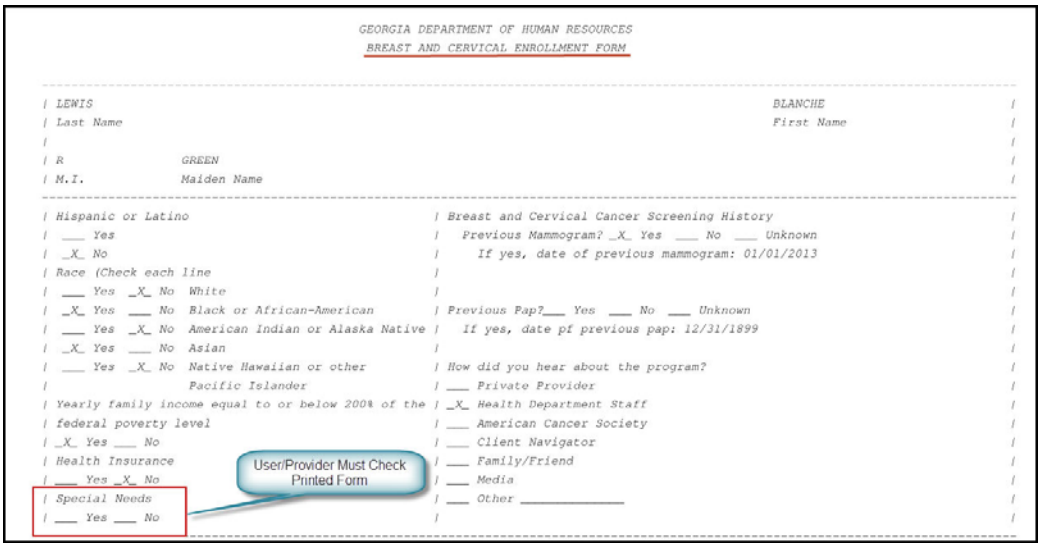


Specific States

Georgia Only

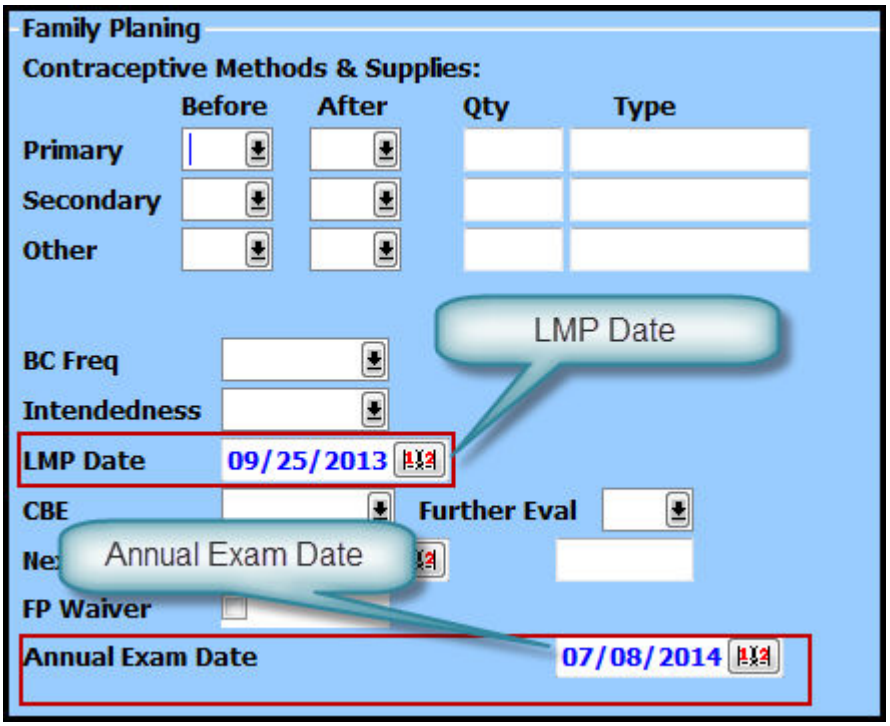
Breast and Cervical Program Enrollment

1. Form changes allow LHD/District to determine Special Needs
    1. Special Needs question remains on form
        1. Yes/No answer display is blank
        2. User/Provider must enter Special Needs based on LHD/District policies
    2. Access the Cancer Screening module
        1. Patient Summary
        2. Adult
        3. Cancer Screen
        4. Select Breast or Cervical to begin
        5. Complete the needed screening information
        6. Output
        7. Enrollment


GEORGIA DEPARTMENT OF HUMAN RESOURCES
BREAST AND CERVICAL ENROLLMENT FORM
LEWIS
Last Name
BLANCHE
First Name
R
M.I.
GREEN
Maiden Name
Hispanic or Latino
___ Yes
_X_ No
Race (Check each line
___ Yes _X_ No White
_X_ Yes ___ No Black or African-American
___ Yes _X_ No American Indian or Alaska Native
_X_ Yes ___ No Asian
___ Yes _X_ No Native Hawaiian or other Pacific Islander
Yearly family income equal to or below 200% of the federal poverty level
_X_ Yes ___ No
Health Insurance
___ Yes _X_ No
Special Needs
___ Yes ___ No
User/Provider Must Check Printed Form
Breast and Cervical Cancer Screening History
Previous Mammogram? _X_ Yes ___ No ___ Unknown
If yes, date of previous mammogram: 01/01/2013
Previous Pap?___ Yes ___ No ___ Unknown
If yes, date pf previous pap: 12/31/1899
How did you hear about the program?
___ Private Provider
_X_ Health Department Staff
___ American Cancer Society
___ Client Navigator
___ Family/Friend
___ Media
___ Other _____

Family Planning

1. Enhancement to the Family Planning Details screen
    1. LMP pulls forward from the previous encounter(s)
    2. Annual exam date pulls forward from a previous encounter
    3. Both fields can be changed as needed
    4. Access the Program Details form the Workflow
        1. Add
        2. Date pull forward after the Add is clicked



2. Family Planning Transmission Date
    1. Added ability to Unflag individual Family Planning Visit forms (famplan)
        1. Query the Family Planning Visit form
        2. Make any corrections needed
        3. View to page 4
        4. Date for Transmission inserted by system when the Visit File is transmitted
        5. Click the Unflag button
        6. Date is removed

Pap Form Change

1. State issued Pap Form change
    1. Form now prints multiple race codes
        1. Client Race indicated as O(ther) on Patient screen
        2. Displays multiple race choices
        3. Click on the race codes that apply

Service Slip Georgia Only

1. Medicaid type will print on the service slip
    1. Must be entered in the 3Pinsurance screen under type
    2. Prints in parentheses next to the Medicaid indication
    3. Prints for:
        1. MPW
        2. Planning 4 Health Babies
        3. Peachcare
        4. SSI Medicaid

Idaho Only

1. Depo Injection Fee
    1. Added reminder to the dispensing screen
        1. When administering Depo warning displays if the injection fee has not been selected from Procedures
        2. Warning displays when user tries to OK the screen
        3. Click OK on the Warning Message to save the record
        4. Does not prevent completion of the Dispensing Screen
        5. Return to the encounter and select the Injection Fee from Procedures

North Carolina

1. Automatic Alert generated
    1. Alert generated to indicate the date of an annual exam
    2. Based on the Preventive services under Office Visit in the Clinical Encounter
        1. When Preventive service selected, alert generates with Exam date
        2. If Encounter voided for any reason the alert will be ended and a note added that the encounter was voided
    3. Displays for any program where a Preventive exam services has been created

Westchester County, New York

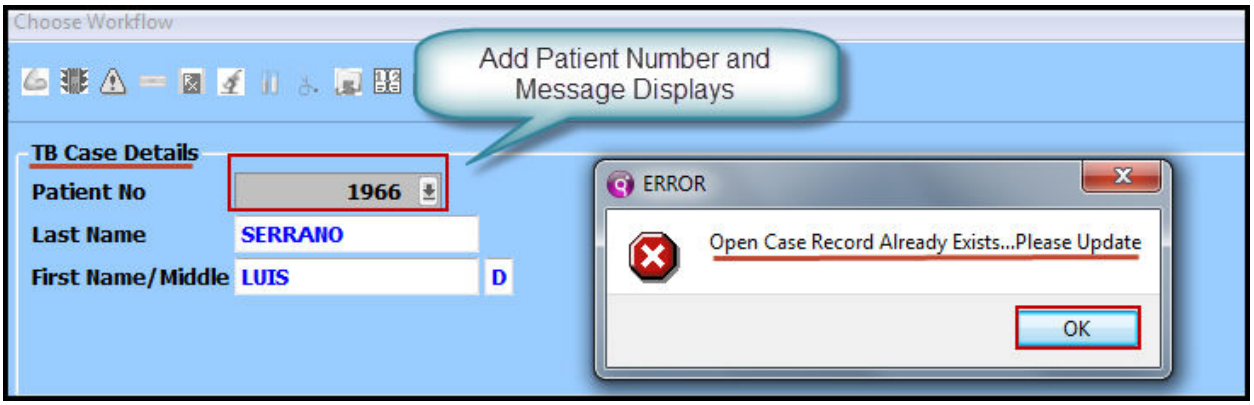
1. Guarantor Table fields
    1. Removed the following from the screen
        1. SSN
        2. Driver's license number
        3. Date of birth
    2. Removed from the Guarantor screens accessed from the following:
        1. Page 3 of Patient Central Registry
        2. Billing Subsystem menu (xGuarantor)
        3. Maintenance Menu
2. Chlamydia Surveillance Form
    1. Added field to form
        1. Test Ordered By
        2. Inserts from the "Ordered By" field in lab orders
    2. From the Lab Orders screen
        1. Choose Output
        2. Chlamydia Form
        3. Form Prints

New York

1. PPD Standing Order
    1. Standing Order inserts automatically into patient's file cabinet
    2. Access TST icon from Patient Summary
        1. Add
        2. Complete screen to the lot number
        3. Click OK
        4. Message to save Standing Order?
        5. Standing Order displays

6. Standing Order inserts into patient's file cabinet

2. TB Case Warning
    1. Warning displays automatically when adding a TB Case if an active Case Record exists for the patient
        1. Access the TB Case Details screen
        2. Click Add
        3. Enter patient number
        4. Message displays that an open case already exists.
        5. Message displays that the Add is Aborted
    2. Query the patient and update record as necessary



System Administration

New Tables and Codes

1. Valid Codes Table
    1. Emergency Contact Relationship field on page 2 of Central Registry
        1. tabname=patsupp
        2. colname=ecrelationship
    2. Relative worktype field
        1. tabname=patsupp
        2. colname=worktype
    3. Religion
        1. tabname=patient
        2. colname=religion
    4. Reason for Visit
        1. tabname = encounter
        2. colname = complaint1
        3. Add program code to limit items in list
2. New Tables
    1. notesigmt
        1. Note Signature Screen
        2. Select only permissions
    2. freqused_meds
        1. Used to store the frequency of use information, by provider, for the Medication Recommendations module
        2. Select permissions for all users
        3. All permissions for providers using the Medication Recommendations module
    3. freqused_snomed
        1. Used to store the frequency of use information, by provider, for the SNOMED Concept IDs and their associated ICD10
        2. Select permissions for all users
        3. All permissions for providers who will use the SNOMED module
    4. labsourcesitemt
        1. Used for lab interfaces
        2. Maintenance done currently by M&M
        3. Select only permissions
    5. reportagerange
        1. Maintenance table to allow local set-up of custom age ranges for reporting
        2. Select only permissions for users that run reports
        3. Select/Update/Insert permissions to do maintenance
    6. requistionnum
        1. Used for lab interface

    2. Generates unique requisition numbers
    3. Select only permissions for users collecting lab specimens
7. eligrecv
    1. Used to do real time eligibility
    2. Users doing real time eligibility will need all permissions.
8. icd10_agency_map
    1. Allows LHD to map SNOMED concept to an ICD-10 code.
    2. All users should have select
    3. System Administrator needs all permissions to maintain this table
9. New First Databank Tables used for Medication Recommendation Module
    1. All users will have Select permission on these tables and the release install will set them as Select. These tables are not in database instance but at the vhn level.
    2. Tables
        1. fst_dxid_search
        2. fst_indcts_mstr
        3. fst_indcts_gcnseqno_link
        4. fst_navigation_desc
        5. fst_labeled_desc
        6. fst_gcnseqno_mstr
        7. fst_hic_therap_class_desc
        8. fst_dxid_syn
        9. fst_ndc_gcn_medid
        10. fst_ndc_medid
10. SNOMED Tables
    1. All users will have Select permission to all these tables and the release install will set them as Select. The exception will be the last 3 tables in the list will need the System administrator to be logged in as Informix to do any inserts, updates or deletes to these tables' These tables are not in database instance but at the vhn level.
    2. Tables
        1. snomed_association
        2. snomed_attribvalue
        3. snomed_codes
        4. snomed_complexmap
        5. snomed_concept
        6. snomed_description
        7. snomed_descriptiontype
        8. snomed_dualkey_concept
        9. snomed_dualkey_description
        10. snomed_extededmap
        11. snomed_identifier
        12. snomed_language
        13. snomed_moduledependency
        14. snomed_refsetdescriptor
        15. snomed_relationship

16. snomed_simplecontent
17. snomed_simplemap
18. snomed_statedrelationship
19. snomed_textdefinition
20. snomed_wordequiv
21. snomed_wordkey_concept
22. snomed_wordkey_description
23. snomed_advice
24. snomed_excludewords
    1. System Administrators will ONLY be allowed to do insert, update and delete as informix log in
25. snomed_to_icd10
    1. System Administrators will ONLY be allowed to do insert, update and delete as informix log in
26. snomed_to_icd9
    1. System Administrators will ONLY be allowed to do insert, update and delete as informix log in

3. New maintenance modules: (These are for future use)
    1. SNOMED to ICD10 Maps
        1. Allows local control of defaults and/or force a default map between SNOMED and ICD10
    2. SNOMED Excluded Words
        1. Allows local control to define the words that can be ignored during a SNOMED concept search
        2. Default list is installed

Chart Notes

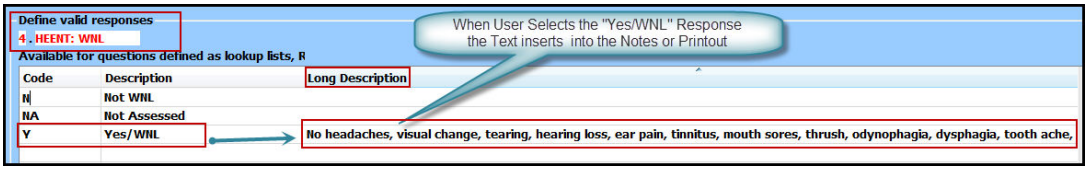
1. Smoking Status added to chart notes
    1. More Maintenance Menu .
        1. Chart Notes
        2. Query ENOTE: only one chart note set-up available
        3. Update
        4. Modify
            1. Select section to add smoking status under.
            2. Section Contents:
                1. Click Button Modify Contents of (name of section) section
                2. Move to a blank line to select the Smoking Status option.

2. Educational Documents
    1. See above
    2. In the Section Contents
    3. Individual documents must be loaded in the Workflow

3. Workflow
    1. Program Details check off
        1. Allows Program Details to check off if no Time and Activity code is assigned
        2. System Administrators will make changes to Workflows if needed

E-charting Maintenance

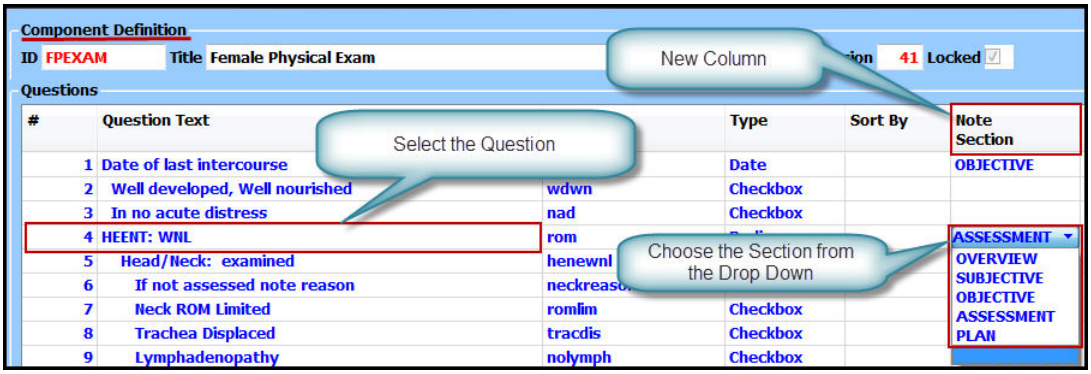
1. Long Description added to responses
    1. Allows a short display on the e-chart screen that generates a longer response on the print out
    2. Response triggers defined text
    3. Limited to the following response types
        1. Lookup
        2. Checklist
        3. Radio
    4. Allows for response to generate standard text
    5. Description is NOT unique to a specific user
        1. Text inserts into printout every time the response is selected
        2. Users must use macros to generate individualized items.
    6. Access E-Chart maintenance
        1. Update the e-chart
        2. Select Advanced
        3. Select Question
        4. Select Field Validation and Update Allowed Responses
        5. Long Description added to the Define Valid Responses screen
    7. Highlight the current response that needs additional information
        1. Place cursor in the new field
        2. Type needed text
        3. Length is limited to 300 characters



2. Note Section ***This is an optional feature***
    1. Sections of the e-chart automatically insert into the Encounter Note
        1. Each question in the e-chart can be assigned to a specific section of the note

2. Multiple questions can be assigned to the same section
3. Not unique to an individual provider. Questions are assigned to sections for all providers using the same e-chart.

2. Access the e-chart as above
    1. Click Update
    2. New column: Note Section
    3. Select the question
        1. Using the drop down choices choose the note section for the response
        2. Items in the drop down are based on the Sections in the Chart Notes Maintenance table.



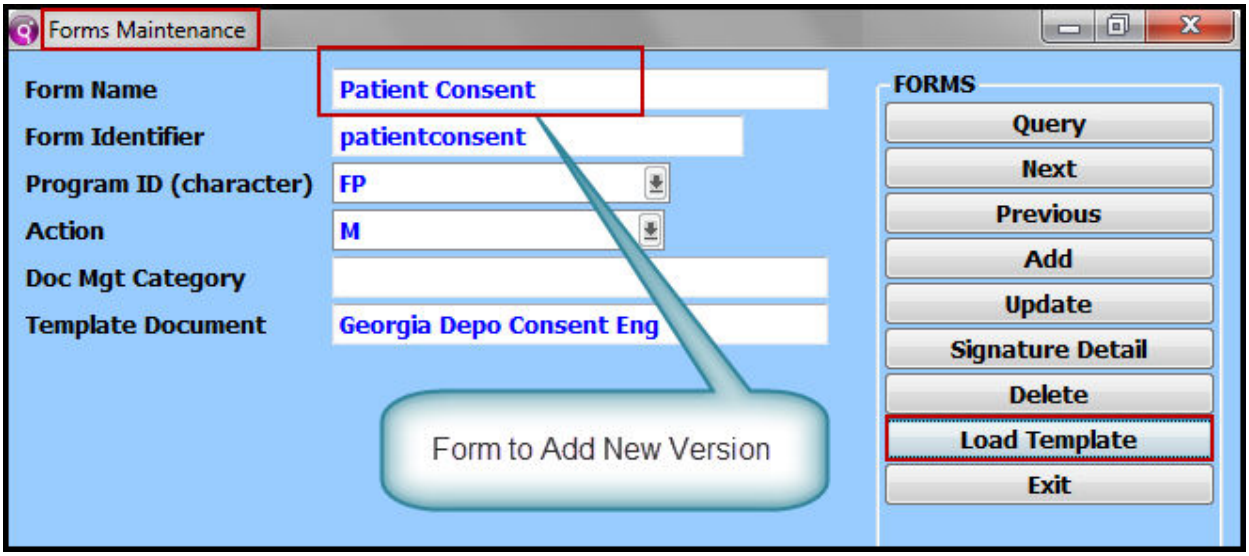
Create Incident

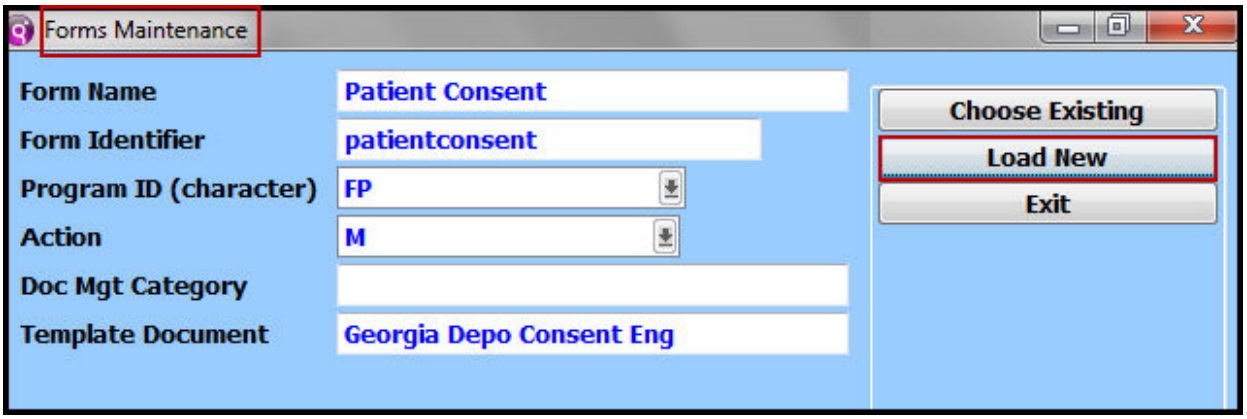
If the the LHD has created an echart in the train instance and wants it moved to production, create an incident to have an e-chart copied over. Include the name of the e-chart, the original database and the new database, any version conflicts that might be expected, changes in the document code or title. Please allow 7-10 working days to complete the process. M&M staff will contact the person submitting the incident with questions and confirmation of the export/import. Allow more time if multiple e-charts are to be moved.

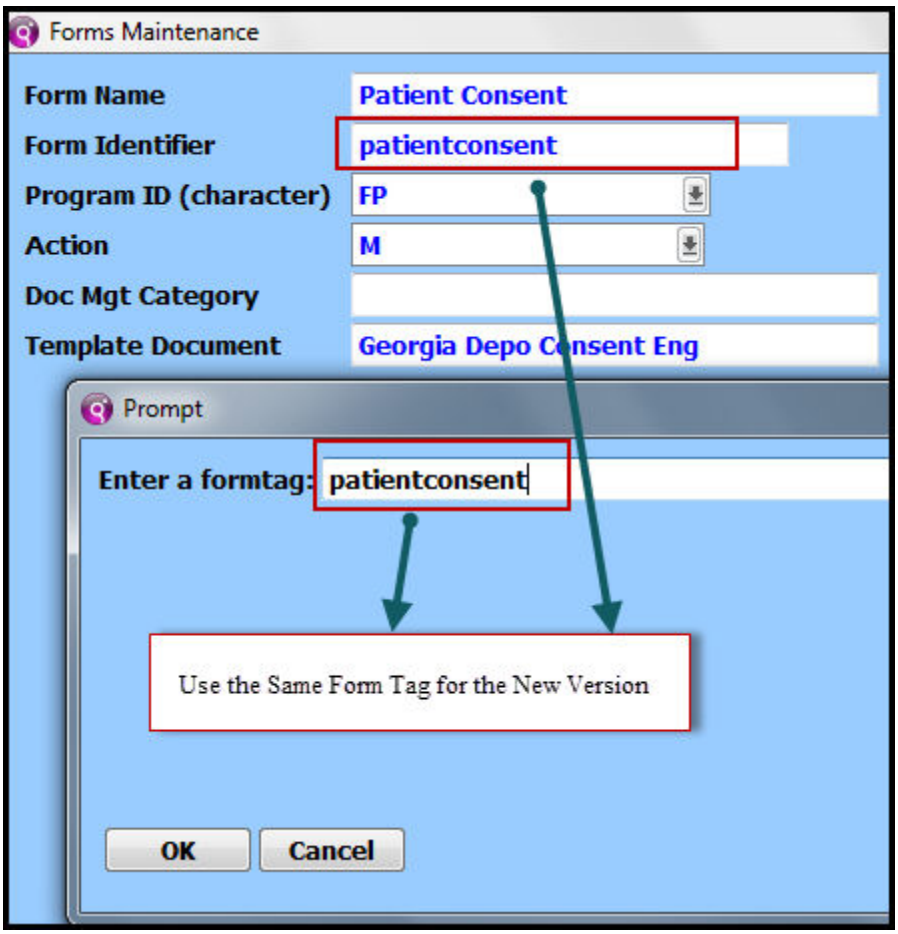
Forms

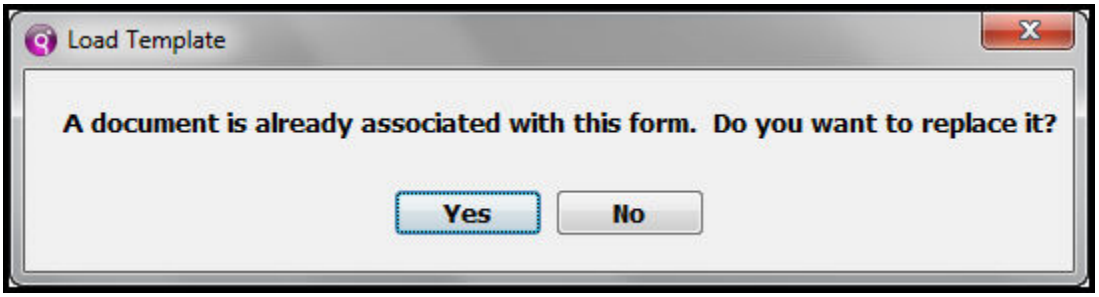
Changing a form version
To create a new version of an existing form

1. Access the Forms Maintenance screen from the Main Maintenance Menu
2. Query the form to be changed
3. Click Load Template
4. Click Load New
5. Message Displays asking if the users wants to replace the current form
6. If Yes: second message displays asking to archive the current form
7. If Yes: ask for a new name for the form to be archived
8. The existing document name is changed and the formtag is removed from it.
9. Load the new version of the document

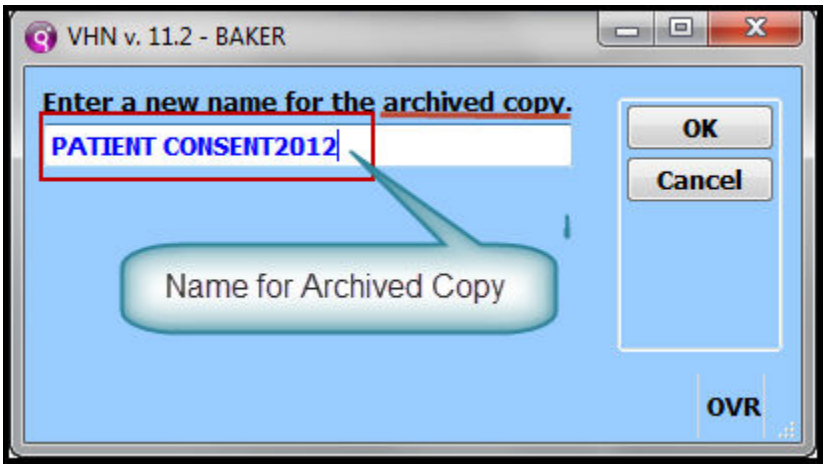





Forms Maintenance
Form Name
Patient Consent
Form Identifier
patientconsent
Program ID (character)
FP
Action
M
Doc Mgt Category
Template Document
Georgia Depo Consent Eng
Prompt
Enter a formtag:
patientconsent
Use the Same Form Tag for the New Version
OK
Cancel


Load Template
A document is already associated with this form. Do you want to replace it?
Yes
No

Load Template
Do you want to archive the current version of your document?
Yes
No


VHN v. 11.2 - BAKER
Enter a new name for the archived copy.
PATIENT CONSENT2012
OK
Cancel
Name for Archived Copy
OVR

HCINFO Screen

1. Optional addition to Appointment Reminders
    1. Access HCINFO from the Maintenance Menu
    2. Query Center
    3. Click View to Health Center Preferences Screen - Scheduling (page 3)
    4. Update
        1. New option:
            1. Optional message to be printed on reminders
            2. Enter message in the box

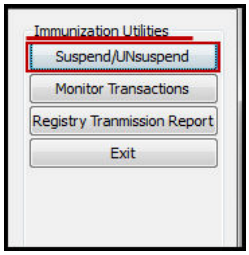
Diagnosis Table

The diagnosis table will now have multiple codes sets in it for use with.

1. The codes currently in the LHD table will be set with the Coding System= ICD-9.
2. The ICD-10 codes are loaded with this release and Coding System=ICD-10. They will not be visible to the user when picking a problem until that are to be used in October 2014.

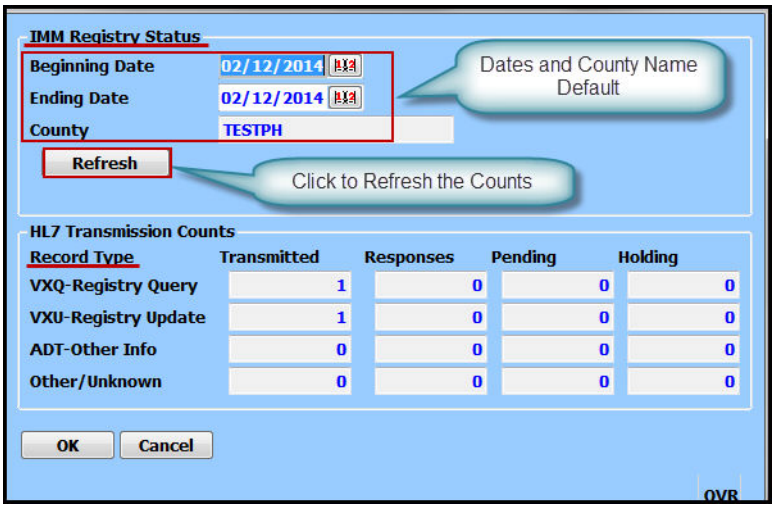
Immunization Interface

1. Real time interface
    1. Monitoring stand alone for Immunization Registry
        1. Allows monitoring of GRITS transaction by clinic users
        2. Requires a password
    2. Suspend/Unsuspend
        1. Click the button: Allows users to stop transmissions
        2. Click button the second time and transmissions resume
        3. Allows users in the clinic to control this process



    3. Monitor Transmissions
        1. Allows users to see the number of HL7 transactions sent and received by GRITS

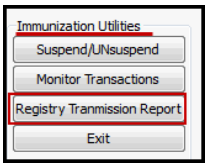
2. Runs for a single county or district wide
3. Real-time monitoring
    1. Includes the 4 types of records used in the transactions
        1. VXQ - the query that goes to the registry
        2. VXU - the Update to the registry
        3. ADT - the patient demographics
        4. Other/unknown
    2. Counts
        1. Transmitted - the number of records of each type that have been sent to the registry
        2. Received - the number of records of each type that have been received from the registry
        3. Pending - the number of records that are sent but no response from the registry
        4. Holding - the number of records that are waiting to be transmitted.
            1. Example: immunizations given or queries done while transactions are suspended to do inventory
            2. Example: immunizations given or queries done when GRITS is not receiving transmissions
4. Enter the date range to monitor: Defaults to today's date
5. Can run for a single county or district wide
    1. County: defaults to the county database where the user is logged in
    2. Can run district wide if in the district database.
6. Refresh: Click to update counts if monitoring in real time.



4. Registry Transmission Reports
    1. Run using multiple parameters
        1. Enter the date range

2. S = number of transactions sent
3. E = number of errors
4. M = number of items missing

2. Runs per center
3. Report runs.



Immunization Registry Reports
Select Type of Report to Run
Beginning Transaction Date
Ending Transaction Date
S for Sent Report,E for Errors,M for Missing
12312013

To be added to a menu. Include the menu to attach the item to. Password will be set-up when added to a menu.

Insurance Table

1. New fields to handle confidential patients and encounters
    1. Must be set for each insurance code
        1. If not checked then defaults to N
        2. Controls the confidentiality of each billing record in the patient's Billing Screen
    2. Options:
        1. Omit Confidential Patients from Billing Generation
            1. If checked "Y", then billing for confidential patients is not included in the generation of the billing file
            2. If blank = "N", then billing continues as before
        2. Omit Confidential Encounters from Billing Generation
            1. If checked "Y", encounters that are confidential, even if the patient is not confidential, will not be included in the generation of the billing file
            2. If blank = "N", then confidential encounters will be included in the generation of the billing file
    3. Flags will be set to "N" by the release install
        1. Each insurance code that needs to be changed to yes must be done individually before tractions are entered.
        2. One or both flags can be set to Yes or No depending on the needs of the LHD

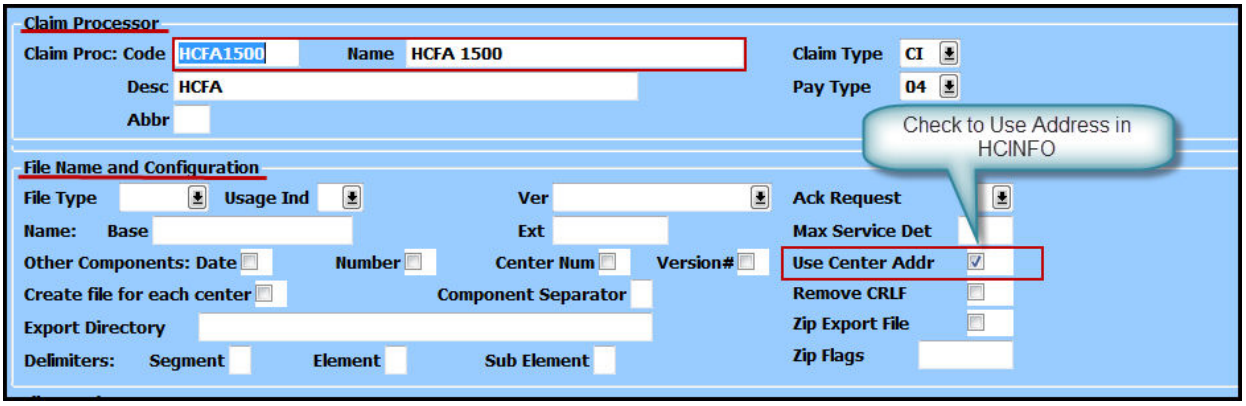
Erie County, New York Only: the Medicare insurance code must be set to "Y" for the Omit Confidential Patient from Billing. This is to continue billing generation that was previously handled by a customized process.

New Tables and Permissions

1. Billing
    1. New posting payments and denial codes (see Non-Clinical, Billing, item 5)
    2. Users doing this function need insert permission on the following tables
        1. htrans
        2. zoom
        3. inserror
        4. mderror
        5. mrerror
        6. mrremit

Printing HCFA Forms

1. Billing Provider Information
    1. Change to process that allows LHD to determine address to print in box 33 of the HCFA Form
        1. Access the Claim Proc option from the More Maintenance Menu
        2. Add record for HCFA
            1. Code = HCFA1500
            2. Check the use Center Address
        3. Access HCINFO
            1. Enter/Update Address
            2. Center Name and Address are used on the HCFA



Program Information Screen

1. Use Alerts
This is used with case management module to display alerts for patients.

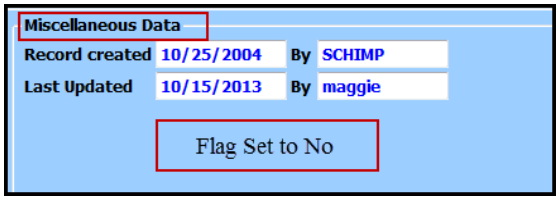
2. Lab ID column added

1. Allows users to identify laboratories based on program and centers
    1. Large laboratories use sub lab ids to identify areas where testing is completed for a specific type of program
    2. May be linked to billing in the future.
    3. Access the Programs menu option on the Main Maintenance Menu
    4. Column added to screen is Lab ID

System Configuration Screen

1. Flag to hide the user name in the Record Created and Last Updated display
    1. Flag controls visibility of the User Name fields only on page 3 of Central Registry
    2. Date record created and last updated continues to display
    3. Flag works for all centers and all programs

To have flag set. Indicate if "Yes" to hide fields or "No" for display to be unchanged

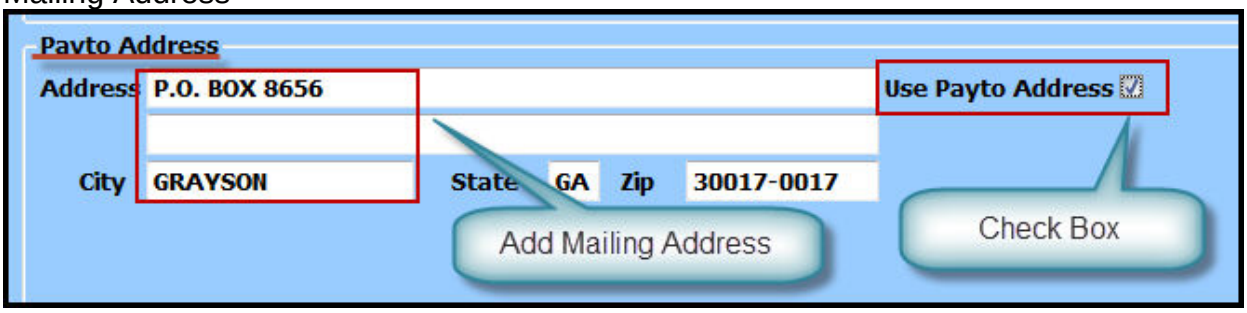


2. Statement address field

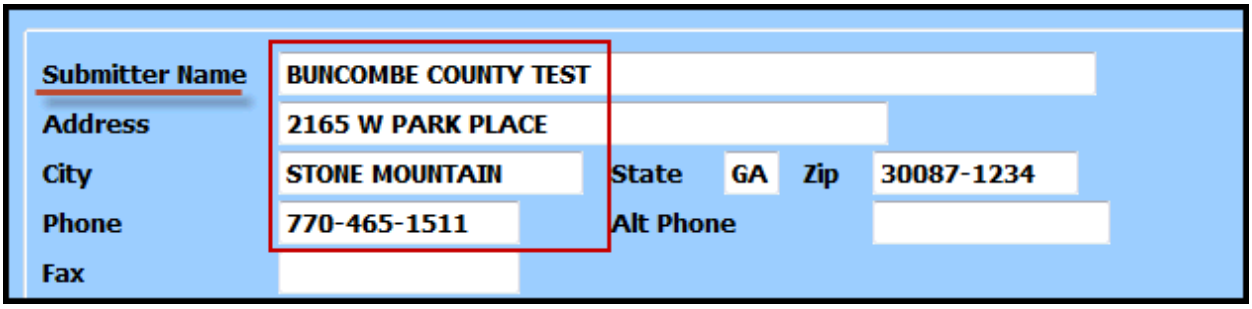
1. Same address used on all statements and transaction printouts
    1. Regular billing statements
    2. Patient and Contractor Statements
    3. Patient and Contractor Transaction lists
2. To use the mailing address
    1. Check flag for Pay to Address

2. Add mailing address to the in the address field in the Pay to Address grid
3. To use physical address
    1. Do not check the Pay to Address
    2. Address in the Submitter grid is used on all statements

Mailing Address



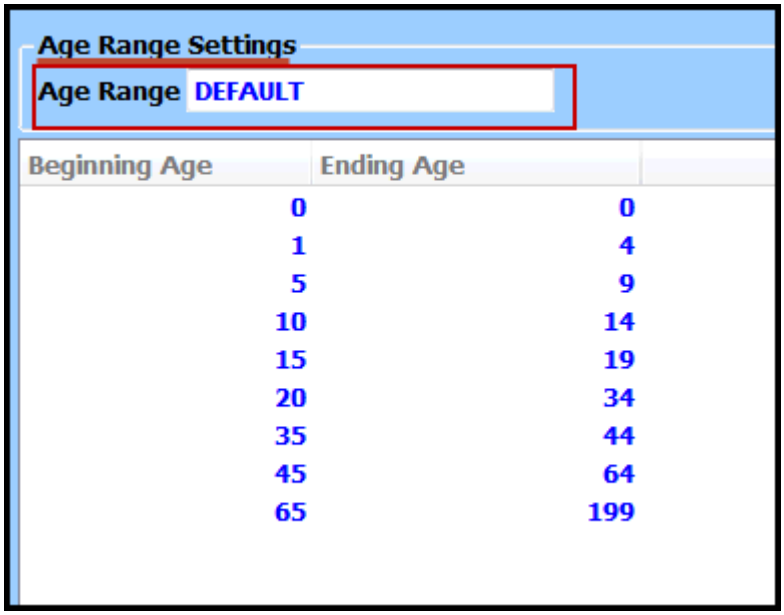
Physical Address



3. Report Defaults
    1. Allows local changes to age ranges for ***Patient Served Summary Reports*** and ***Payer Mix by Age*** reports. If LHD needs this feature in other reports, an incident needs to be put into help desk requesting this and specifying exactly which report to add this feature
    2. If more than 1 age range is available for these reports, the user will be asked which one to use for the report.
    3. Default age range was added as part of the 11.3 release.
    4. System Admin staff needs to add the other choices that will be used by programs.

From ***System Configuration*** module, click button ***Report Defaults***
Click ***Age Ranges***

Query to see what is already set up. ***Default*** and any others will appear. At bottom of screen the number of age ranges found will show. Use ***Next*** to go to the others. Use Add to add a new set of age ranges. Be sure and cover all ages in the ranges. Look at the default record to see an example.



4. Problem List with ICd-10 and SNOMED Concepts
   1 First step toward conversion to ICD-10 and SNOMED for Problem List
   2 Flag created to turn the SNOMED feature on in the Problem List
   3 Flag set to "Y" users will see ICD-9 and SNOMED as part of Problem List
   4 Flag set to "N" users will continue to see Problem List in current format
   5 Flag will be set to No when release installed and turned on when activated by Mitchell and McCormick

Workflow

1. Workflow Items
    1. Workflow items divided into 2 groups
        1. Those that require a Time and Activity code to generate a Green Check on the workflow
        2. Those that DO NOT require a Time and Activity code to generate a Green Check on the workflow
    2. Workflow items that require a Time and Activity code
        1. Generate a time entry in the user's Time and Activity record for the day
        2. Are displayed on the System Generate view of Time and Activity (see Time and Activity Screen notes)
        3. Listed below:
            1. ACCU Referral
            2. Add HH Orders
            3. Approve Final HH Bill
            4. Breast Cancer Screening
            5. Cancer Screening
            6. Cervical Cancer Screening
            7. Central Registry
            8. Check Encounter
            9. Collect Lab Samples
            10. Current TB Med Order
            11. Current TB Meds
            12. HH Care Plan
            13. HH Episode
            14. Home Health Orders
            15. HH Patient Master List
            16. HH Referral
            17. Home Health Visits
            18. ID Referrals
            19. Labs
            20. Lab History Screen
            21. Maternal Health Visit
            22. Maternal OB Screen
            23. Mini Registry
            24. Miscellaneous Orders
            25. Order Set
            26. Order Sets/Program
            27. Outprocessing
            28. Perinatal Summary
            29. Print TB Cardex
            30. Print TB Contact Worksheet

31. Print TB Intake Sheet
32. Print TB Risk Assessment Form
33. Prioritize Diagnosis
34. Process Claims
35. Produce Final Oasis
36. Progress Note
37. Referrals
38. Radiology Orders
39. Review Final Oasis
40. Review Lab Results
41. Review Orders
42. Review Task List
43. ROC Oasis
44. Ryan White
45. Scheduler
46. SHAPP Status
47. TB Health Assessment
48. TB DOT
49. Time and Activity Screen
50. Transportation EVS
51. WWW Link
52. X-Ray Orders
53. X-Rays

3. Workflow items that DO NOT require a Time and Activity code to be checked
    1. Time and Activity code is optional
    2. Time inserts into the Time and Activity screen if a code is assigned to the Workflow item
    3. List
        1. Vitals Entered for same date of service as encounter
        2. Lab orders
        3. Med orders
        4. Meds reviewed
        5. Echart Yellow check mark if started but not signed. Green if signed OR locked by encounter closing.
        6. HIV counseling – HIV screen record associated with encounter
        7. Referral orders
        8. Appointment orders
        9. Immunizations - Immunizations given or if none given, immunizations reviewed
        10. Allergies - allergies documented or if none document, allergies reviewed
        11. 3p insur - added or updated insurance record
        12. PPD - if Skin test record linked to this encounter or has a read date that is the same as this encounter date

13. TB med orders entered
14. Problems reviewed
15. Ed document selected and viewed or printed from PDF Viewer screen
16. Merge document completed
17. Office visit for current encounter
18. Procedures
19. Ed topics
20. Encounter info - if visit type has been entered
21. Signed encounter note
22. Pregnancy test - pregtst record associated with this encounter
23. Smoking status - smoking status completed
24. GA school screening - if vision, hearing, dental, and nutrition done then green checkmark; if some but not all, then yellow checkmark
25. Program details

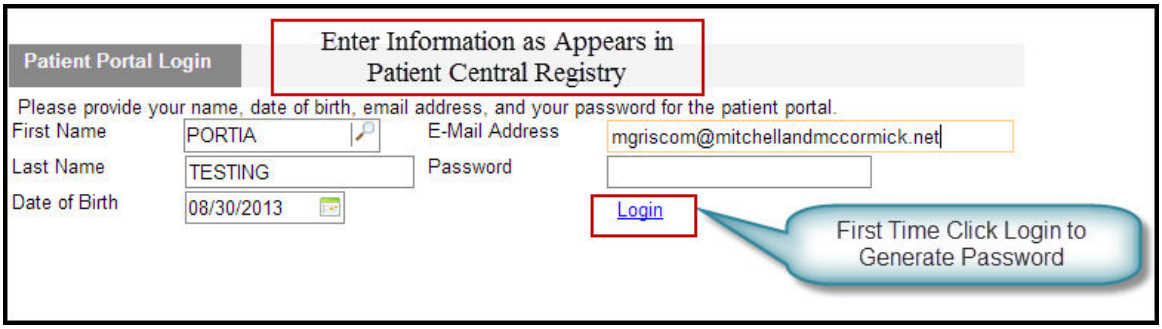
4. Additional Workflow items are added by M&M with new versions.

To have a workflow item created. Include desired action and name for the workflow step. Workflow steps will be added with the next release.

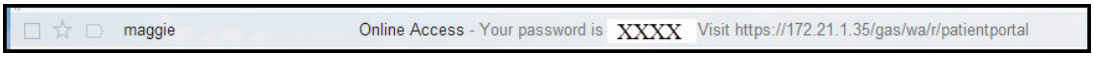
Patient Portal

- LHD needs to provide a separate Web Server. M&M will assist in the configuration of the server for access to the patient portal
- When email is entered and Available in Portal is marked Yes, then an email is sent to the patient with a web address to access and a login.
- The patient will have access to their Health Summary after they complete the set up of their account.

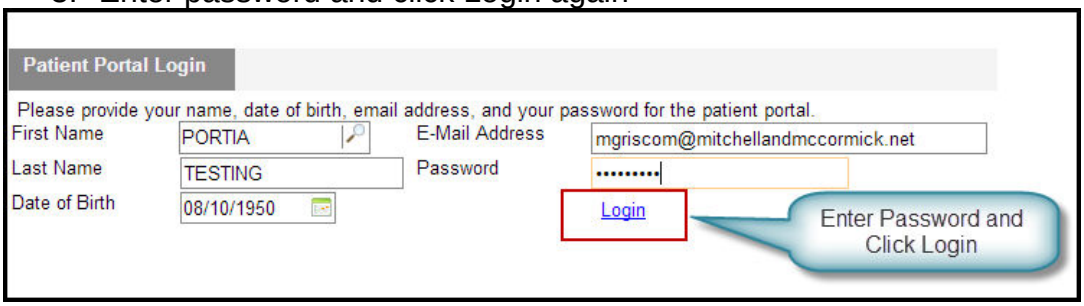
1. To allow patient access to the Patient Portal
    1. Add/Update Patient Central Registry screen
        1. Patient Central Registry must be complete
            1. Items that must be completed
                1. Patient name
                2. Patient date of birth
                3. Patient e-mail address
                4. Patient contact preference
                5. Available in Portal must = "Yes"
                6. Patient address
                7. Emergency Contact name
            2. Available with Family
                1. Optional
                2. Allows family members linked by family number access to other family members records
                    1. Mother access to children's records
                    2. Spouse/partner's access to each other's records.
                    3. Only available if the patient's Available with Family = "Yes"
2. Patient Portal Login
    1. Patient provided with information on access to the Portal
        1. LHD provides patient with access information: URL or Website
        2. To obtain a password: Information must match Patient Central Registry exactly
            1. Patient goes to website
            2. Enters Name, date of birth and e-mail address
            3. Click login
            4. VHN randomly generates a password and sends to the patient at the e-mail address in Patient Central Registry



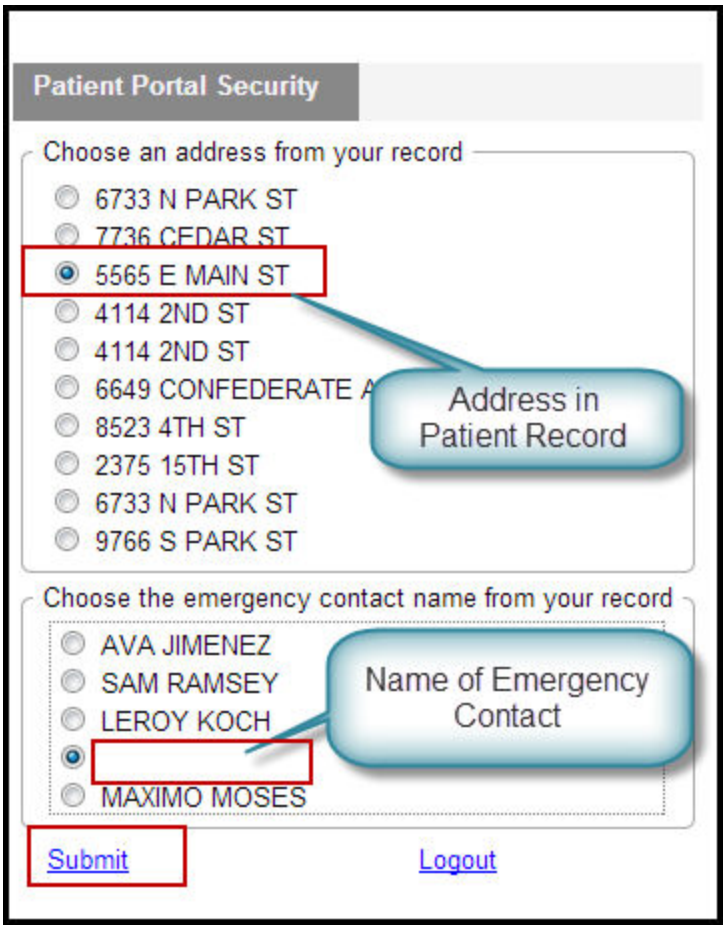
Advise patients to look in SPAM folder if password does NOT come immediately to in box.



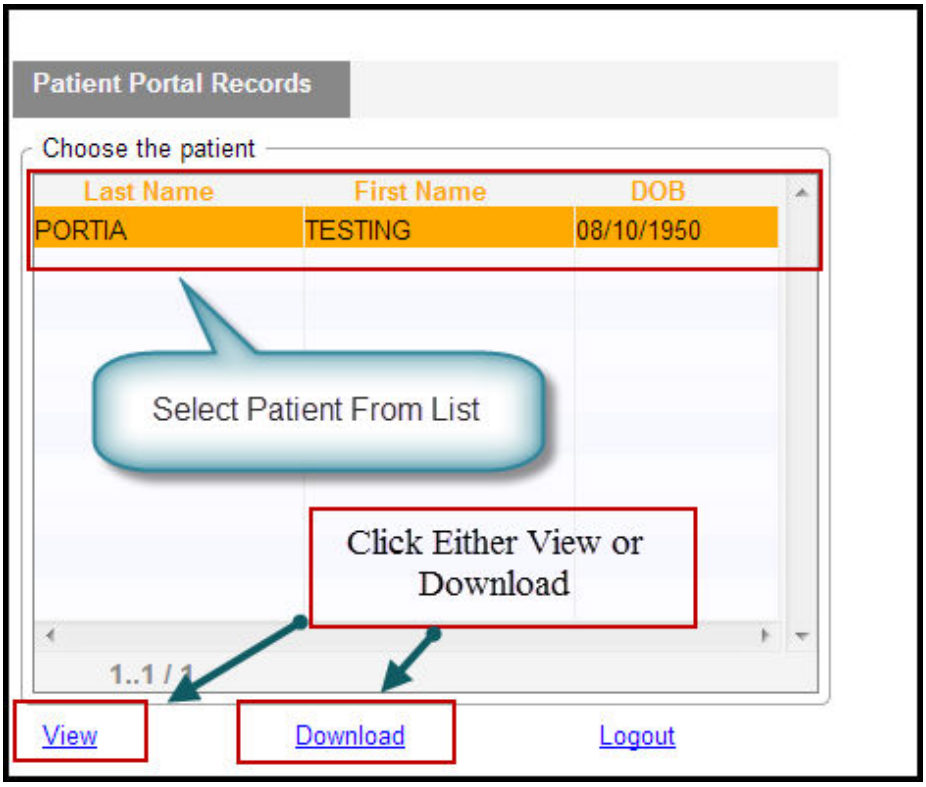
3. Enter password and click Login again



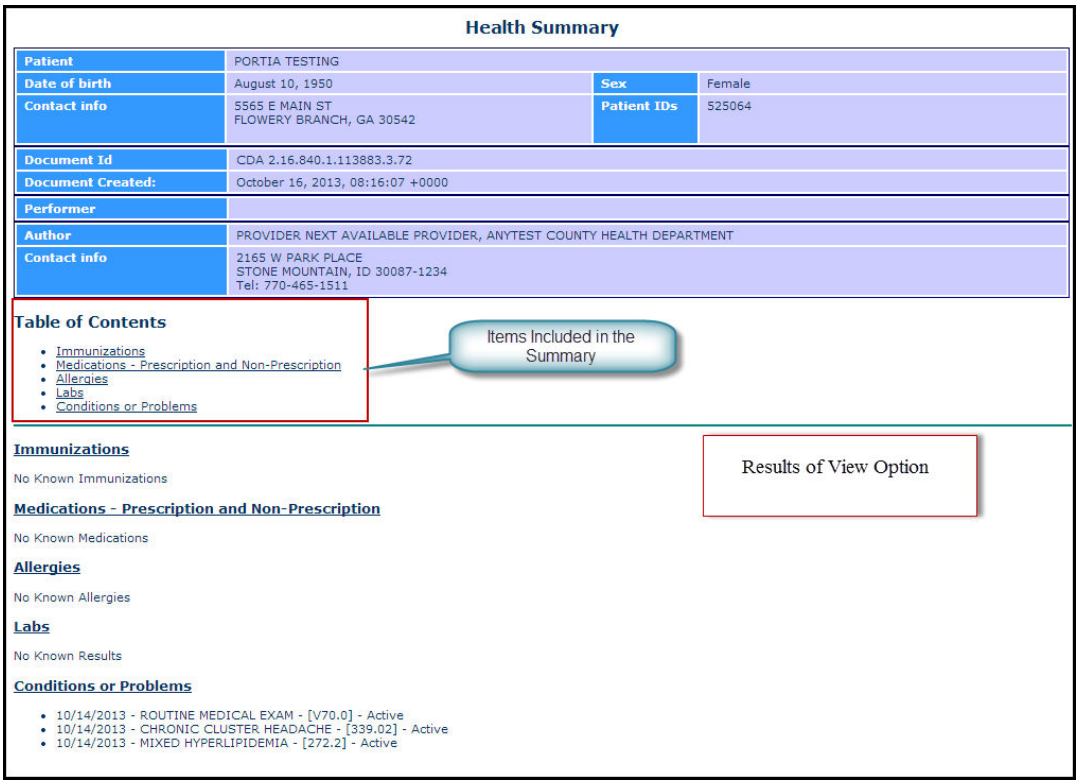
4. Patient Portal Security displays
    1. Patient must choose their address from a list of 10
    2. Patient chooses a name in their record. If field is blank user can choose the Blank
    3. Click Submit



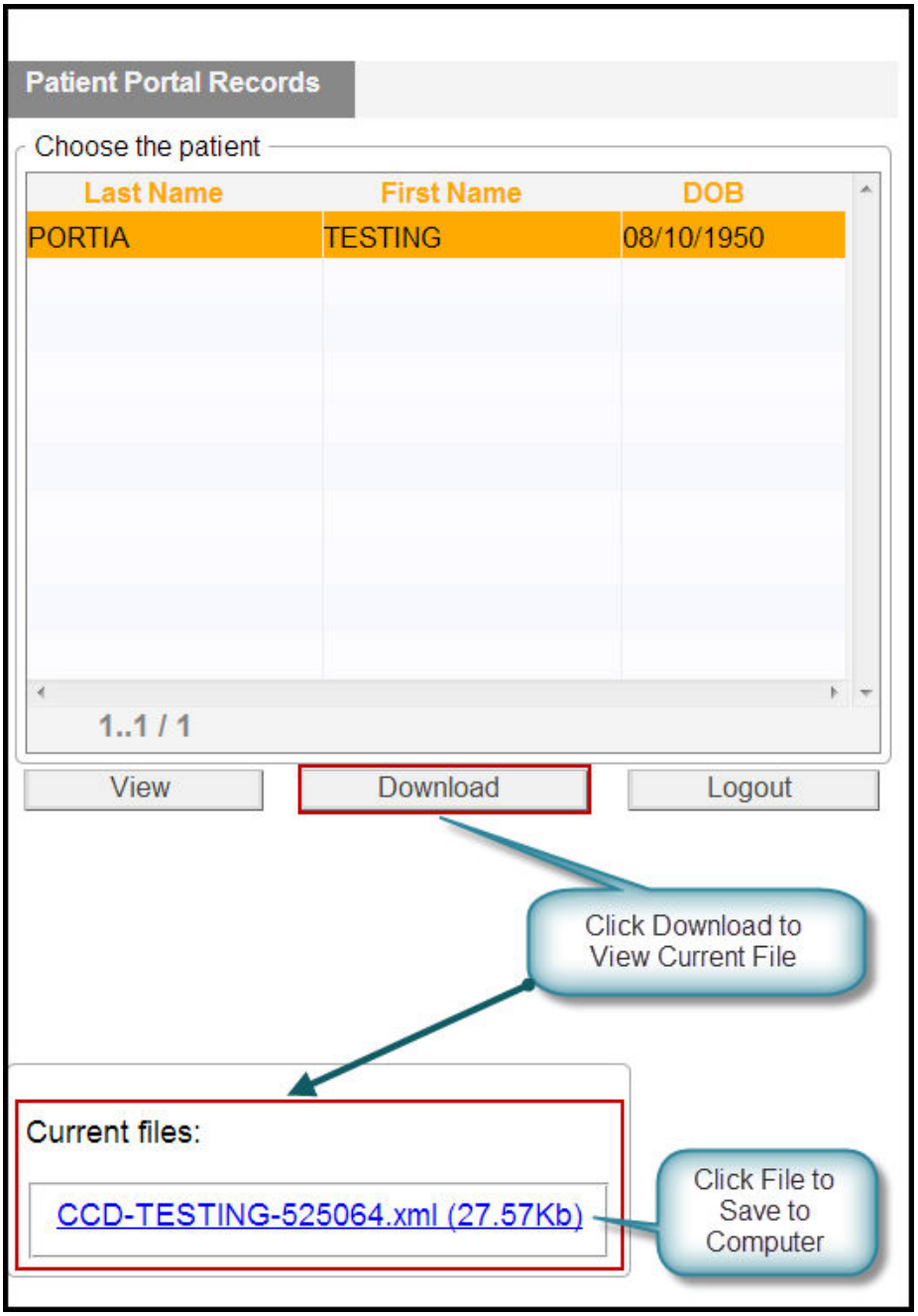
4. Information does not match:
    1. Screen returns to initial login screen
    2. Repeat entering the name, date of birth and e-mail address
    3. Re-enter password
5. Information matches items in patient record
    1. Presented a list of accessible patients
        1. Only lists patient if Available with Family = "No"
        2. Lists contains family members if Available with Family = "Yes"
    2. Select the name of the patient requesting information for



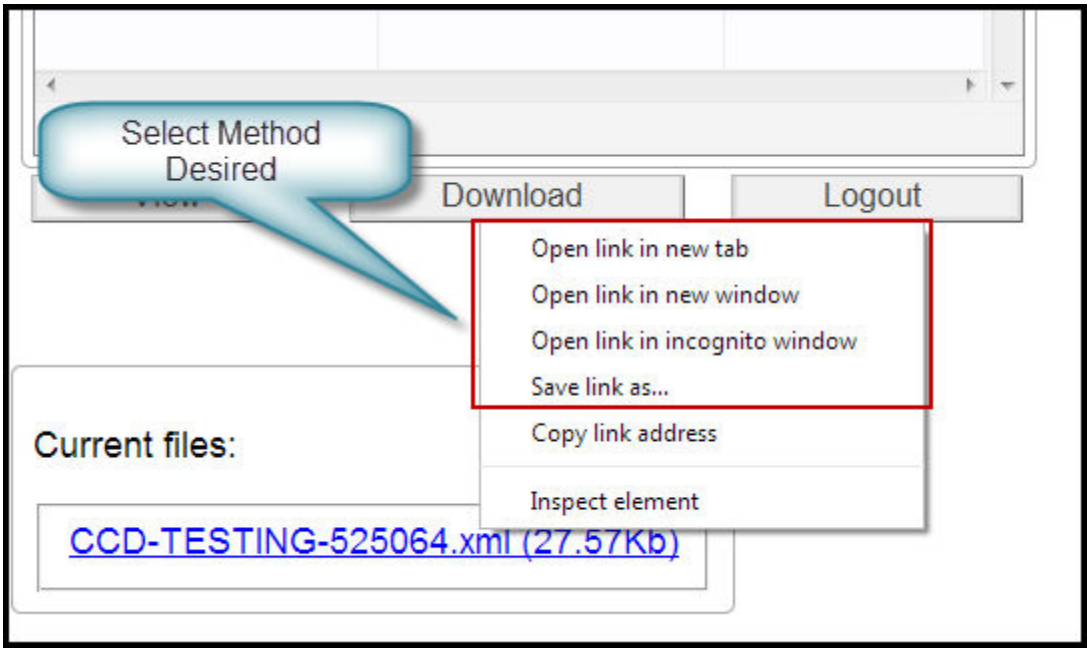
1. Click View to view the patient information Below is example of Summary

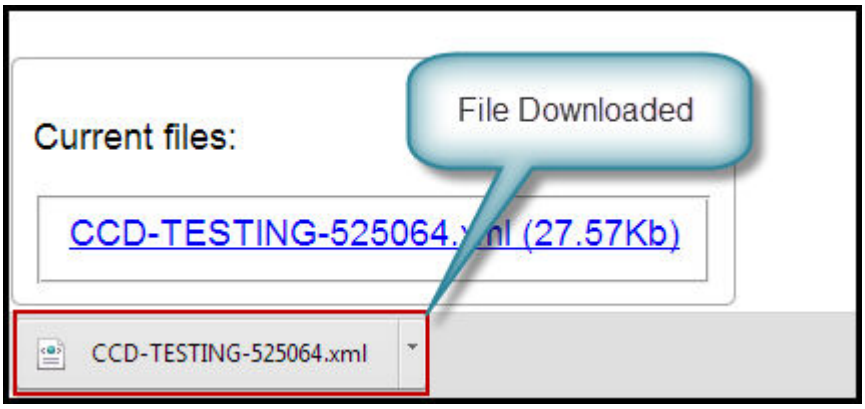


2. Click Download to save a copy of the record to their computer.
    1. File information displays at bottom of window



2. Right Click the file information to display the download to save





3. File is in XML format
    1. Intended to be saved to client pc
    2. Saved file is transmitted to another provider electronically
    3. Must be in XML format to be transmitted

3. When finished click Logout